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ROYAL COMMISSION OF INQUIRY INTO CERTAIN  
DEATHS AT THE HOSPITAL FOR SICK CHILDREN AND  
RELATED MATTERS.

Hearing held  
8th floor  
180 Dundas Street West  
Toronto, Ontario

*Mancos (Cont'd)*

*X Labao  
Shinehoff*

The Honourable Mr. Justice S.G.M. Grange

Commissioner

P.S.A. Lamek, Q.C.

Counsel

E.A. Cronk

Associate Counsel

Thomas Millar

Administrator

*Re: Scott*

*Cham*

*Pfaff*

Transcript of evidence  
for  
September 29, 1983

*Contz In Chief*

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ROYAL COMMISSION OF INQUIRY INTO CERTAIN  
DEATHS AT THE HOSPITAL FOR SICK CHILDREN  
AND RELATED MATTERS.

Hearing held on the 8th Floor,  
180 Dundas Street West, Toronto,  
Ontario, on Thursday, the 29th  
day of September, 1983.

- - - -


THE HONOURABLE MR. JUSTICE S.G.M. GRANGE - Commissioner  
THOMAS MILLAR - Administrator  
MURRAY R. ELLIOT - Registrar

APPEARANCES:

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L. CECCHETTO	Counsel for the Attorney- General and Solicitor General of Ontario (Crown Attorneys and Coroner's Office)
I.G. SCOTT, Q.C.)	Counsel for The Hospital for Sick Children
R. BATTY )	
M. THOMSON )	
D. YOUNG	Counsel for The Metropolitan Toronto Police
K. CHOWN	Counsel for numerous Doctors at The Hospital for Sick Children
B. SYMES	Counsel for the Registered Nurses' Association of Ontario and 35 Registered Nurses at The Hospital for Sick Children

(Cont'd)





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APPEARANCES (CONTINUED):

D. BROWN	Counsel for Susan Nelles - Nurse
E. FORSTER	Counsel for Phyllis Trayner - Nurse
J.A. OLAH	Counsel for Janet Brownless - R.N.A.
S. LABOW	Counsel for Mr. & Mrs. Gosselin, Mr. & Mrs. Gionas, Mr. & Mrs. Inwood, Mr. & Mrs. Turner, Mr. & Mrs. Lutes and Mr. & Mrs. Murphy (parents of deceased children)
W.W. TOBIAS	Counsel for Mr. & Mrs. Hines, (parents of deceased child Jordan Hines)
F.J. SHANAHAN	Counsel for Mr. & Mrs. Dominic Lombardo (parents of deceased child Stephanie Lombardo); and Heather Dawson (mother of deceased child Amber Dawson)
J. SHINEHOFT	Counsel for Lorie Pacsai and Kevin Garnet (parents of deceased child Kevin Pacsai)





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/BB/ak

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---Upon commencing at 10:00 a.m.

3

THE COMMISSIONER: Yes, Mr. Labow.

4

DR. JAMES FREDERICK KENT MANCER, Resumed

5

CROSS-EXAMINATION BY MR. LABOW:

6

Q. Thank you, sir.

7

Doctor, it is my understanding from your evidence and Dr. Becker's evidence that prior to performing an autopsy the resident reviews the Hospital record of the child?

8

9

10

A. Yes.

11

12

Q. How does he do it, does he review the entire record that we have been given, for example?

13

14

A. No, he wouldn't read every page.

15

Q. Well, what kind of things would he look for in a record?

16

17

A. Well, I think it would depend on the resident but the main things he would look for would be the clinical course of the patient. He's going to be making a clinical pathological correlation and that's what he would focus on.

18

19

20

21

Q. So, I would guess he would read the progress notes carefully?

22

23

A. That would be a large part; the progress notes, the consultations and probably

24

25







1  
2 the admitting history and probably the front sheet,  
3 which is the admission to the Hospital.

4 Q. Now, would he have any  
5 discussions with any of the clinicians?

6 A. He may.

7 Q. Generally, as a routine matter  
8 would he discuss the situation with any of the  
9 clinicians on the floor?

10 A. Not as a routine matter.

11 Q. Now, I am led to understand  
12 that he would make certain notes and then discuss  
13 that with the staff pathologist in charge?

14 A. That's correct.

15 Q. Sometimes in person, sometimes  
16 over the phone?

17 A. That's correct.

18 Q. What would happen to those  
19 notes?

20 A. Well, they would become the  
21 first part - they would be the basis for the first  
22 part of the preliminary autopsy report.

23 Q. Would they be kept anywhere  
24 in particular, would they be destroyed once they  
25 were used, do you have any idea?

A. I suppose it would depend on





1  
2 the resident. Some might kept them, some might  
3 destroy them. I really don't know.

4 Q. There is no general rule that  
5 they for example go into the zebra pack?

6 A. The zebra pack?

7 Q. Well, on the floor the treating  
8 doctor has a separate record of some kind with notes.  
9 There is no general instructions for what to do with  
10 these notes?

11 A. No.

12 Q. Now, the idea of that, I'm  
13 lead to understand, is so that we have an idea of  
14 the clinical diagnoses, the clinical differential  
15 diagnoses of the child.

16 A. Yes.

17 Q. Now, is there any particular  
18 discussion as to what the cause of death appears to  
19 be prior to going through the autopsy itself.

20 A. There may be. If there was  
21 a definite apparent cause of death. It would be  
22 mainly the clinical diagnoses that would be discussed.

23 Q. Now, are those clinical  
24 diagnoses determined by the resident from the notes?  
25 My understanding reading through the progress notes  
is, I don't often see an actual diagnosis written







1  
2 down, just observations of the doctors and of the  
3 nurses.

4 A. Well, ordinarily at the  
5 beginning when the patient is admitted, a history  
6 and physical examination is done and whoever did that  
7 will make a list of diagnoses. That would be one  
8 list of diagnoses/also appear on consultants reports  
9 and then there may be some more diagnoses added  
10 from the progress notes to become apparent during  
11 the course in the Hospital.

12 Q. Okay, but routinely after  
13 going through the notes, if the child had been  
14 there for any extended stay and there were no actual  
15 diagnoses written down in the progress notes it  
16 would be the residents evaluation.

17 A. If the resident was the only  
18 one that sought the patient that would be the  
19 basis, the entire basis for the valuation.

20 THE COMMISSIONER: Which resident  
21 did you mean?

22 MR. LABOW: I mean the pathology  
23 resident.

24 THE WITNESS: Oh, I assumed that  
25 you meant the clinical resident.

MR. LABOW: Q. No, Let me clarify







1  
2 that. There is a situation where the pathology  
3 resident takes part of the hospital record, goes  
4 through it, takes whatever diagnoses are evident  
5 in the admission notes and the consultation note  
6 and if there are no other actual diagnoses in the notes  
7 is it the pathology resident's evaluation of the  
8 clinical history that gives you these clinical  
9 diagnoses that appear?

10 A. Yes.

11 Q. I assume in discussion with  
12 the staff pathologist?

13 A. Yes.

14 Q. Now, the very top of any  
15 particular autopsy, just under the basic information,  
16 above a dotted line there is generally in block  
17 caps either congenital heart disease or something  
18 to that effect. Dr. Becker has said that that is  
19 the main disease?

20 A. Ordinarily it is a title for  
21 the type of autopsy, the main disease would be  
22 there.

23 Q. Now, is that based upon the  
24 pathology resident's evaluation or something taken  
25 directly out of the notes?

A. No, it is based on the





1  
2 pathologist and the pathology resident's combined  
3 opinion.

4 Q. And is that something that  
5 you understand to be the case before you undertake  
6 the autopsy or is that after you have gone through  
7 the entire autopsy?

8 A. Well, in the case of the  
9 preliminary it is after the autopsy is finished,  
10 but the microscopic and all the other data are not  
back yet.

11 Q. It is after the gross autopsy?

12 A. Yes. In the case of the  
13 final autopsy report it may alter it, depending  
14 upon the microscopic findings and one may change  
15 that title.

16 Q. Now, you told Mr. Hunt yesterday  
17 that your knowledge of digoxin and the therapeutic  
18 range came from a table that you had and your  
general knowledge on digoxin.

19 A. Yes.

20 Q. Do you know if the residents  
21 in the period that we are concerned with had any  
22 specific knowledge about digoxin and the therapeutic  
23 range, for example?

24 A. You mean the pathology  
25 resident?







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Q. Well, it is my understanding that Dr. Taylor did discuss the high level with his colleagues in the resident's room?

A. They all agreed that it was high, but I think their opinion was similar to everybody else's, that it was so high as to be unbelievable. But they must have had a basis for that. Like, they must have known the therapeutic range also.

Q. Okay. Well, did you have any knowledge of the symptoms associated with digoxin intoxication?

A. I have some general knowledge of that.

Q. Then do you know if the residents for example, would have a general idea?

A. I expect they would.

Q. So, you would expect if they read through a chart and there were symptoms of digoxin intoxication they would recognize that as a possible digoxin intoxication?

A. I don't think the symptoms are specific enough that they would really notice that unless somebody made a statement, some clinical person made a statement of concern.

Q. So, if there wasn't something





1  
2 written down in the chart or told to them, they  
3 wouldn't look at those symptoms as possible digoxin  
4 intoxication?

5 A. There are usually so many  
6 statements that are in charts that the chances  
7 of a person picking up something like that and  
8 really becoming aware of the possibility of  
9 digoxin intoxication when nobody else had, is very  
10 low I would think. I think if there had been some  
11 clinical statement saying possible digoxin intoxica-  
12 tion, then that might raise the possibility.

13 Q. If those questions were  
14 raised, what would the people in the pathology do  
15 to investigate that, the possibility of digoxin  
16 intoxication?

17 A. To my knowledge the situation  
18 has never come up before, so, I just can't say what  
19 we would do.

20 Q. Well, we have heard that in  
21 one case at least a digoxin assay was ordered post  
22 mortem.

23 A. Yes.

24 Q. Is that the only thing that  
25 you can think of that would be done?

A. Yes, that could be done.







1  
2  
3 Q. Well, if you had suspected  
4 for some reason, if you suspected digoxin intoxica-  
5 tion as a possible diagnosis to the death of a  
6 child, could you order a digoxin assay yourself?

7 A. Certainly.

8 Q. Have you ever done that?

9 A. No, not until after the  
10 events of the weekend of the Cook/Miller - after  
11 that time it became routine.

12 Q. If that had happened, would  
13 you discuss it with the clinician first or just  
14 order the assay on your own?

15 A. Well, if I was ever in a  
16 situation where the possibility of digoxin intoxica-  
17 tion was causing the death, I would have  
18 just ordered it on my own. I might have called  
19 the clinician to ask him how certain he was, whether  
20 he thought it might be a cause of death, but I  
21 would generally order things on my own.

22 Q. Now, you have told Mr. Lamek  
23 at least with regard to the Estrella autopsy that  
24 Dr. Taylor worked under your supervision?

25 A. That's correct.

Q. How do you supervise a  
resident's autopsy?





1  
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3 A. Well, the main thing is that  
4 we go over the autopsy history beforehand with him  
5 verbally and then the other thing that we do is  
6 go over the case microscopically with him and  
7 create a final report. In the interim there would  
8 be a preliminary report. We may also be involved  
9 related to looking at the autopsy, if he has any  
10 finding during the autopsy he wants to discuss.

11 Q. I would like to refer to  
12 Exhibit 69, that's the Lutes child. The Registrar  
13 will put it in front of you.

14 Now, in this case, you have apparently  
15 done both the preliminary and final autopsy report  
16 because your signature appears on both. I can tell  
17 you that the preliminary report is at page 36 and  
18 the final report is in two spots in this record at  
19 page 19 and 31.

20 A. Yes.

21 Q. Now, is there anything  
22 significant in the fact that both yourself and  
23 Dr. Gray signed both reports? That's not the case  
24 in all situations, I was just wondering if there  
25 was anything significant in that?

A. There is nothing particularly  
significant in it except that it means that Dr. Gray







1  
2 read both reports, proof read them after as well  
3 as me.

4 Q. Fine. Now, in this case,  
5 this child was admitted to the Hospital on the 12th  
6 of November and on the 15th of November digoxin was  
7 ordered held and then restarted the next day.  
8 Dr. Rowe has told us, and this is at Volume 14,  
9 page 2437 and 8 that although the level at that  
10 time was only 2.1, once they had done an assay,  
11 digoxin was probably held because the child had been  
12 vomiting and that level might have been too high for  
13 this particular child. Do you recall the resident  
discussing that possibility?

14 A. Well, the resident's summary  
15 of the case ordinarily wouldn't go into that sort  
16 of detail.

17 Q. Okay. Now, do you recall  
any discussion at that time?

18 A. No, I don't.

19 Q. Now, two of the more repetitive  
20 symptoms for this child in the five days that he was  
21 at the Hospital and his terminal events were that  
22 he was bradycardic and vomiting. Now, we have been  
23 told that those are two symptoms of possible  
24 digoxin intoxication. Do you understand that to be  
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the case, first of all?

A. Well, certainly they are related to digoxin intoxication.

Q. But you don't recall it being brought to your attention at any time in this particular case?

A. No.

Q. Now, I'd like to look at Exhibit 72, that's the Gosselin baby's Hospital record.

In this record, Doctor, your signature appears on both the preliminary report at page 32 and the final report at page 27. Now, this child was admitted on the 17th of December from another hospital and had a digoxin level of either 3.7 or 3.9 and died very early the next morning. Was the fact of the high level on admission and the holding of digoxin on admission brought to your attention with regard to this child?

A. I don't recall.

Q. Do you think it should have been brought to your attention prior to the autopsy of this child?

A. I wouldn't fault the resident if the resident hadn't, I will put it that way.







1  
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3 Q. I'm not faulting the resident  
4 for anything, Doctor, I am just asking if you think  
5 that kind of a level should have been brought to  
6 your attention as the supervising pathologist?

7 THE COMMISSIONER: Brought to his  
8 attention by whom?

9 MR. LABOW: By someone. Either the  
10 pathology resident or someone on the cardiac floor.

11 THE COMMISSIONER: I'm sorry, what  
12 reading is this for Gosselin, what reading is it?

13 MR. LABOW: 3.7 or 3.9. That's at  
14 pages 55 and 21. There was a difference in the  
15 numbers, no one can decide why there were two  
16 different readings but it was one of the two  
17 apparently.

18 THE COMMISSIONER: Page 57?

19 MR. LABOW: 55 of the Hospital  
20 record

21 THE COMMISSIONER: 55 and what other  
22 page?

23 MR. LABOW: 21 in the discharge  
24 letter.

25 THE COMMISSIONER: Oh, I see.

MR. LABOW: That was referred to,  
that is 3.9 right in the middle of page 21.





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Q. My question is, do you think that kind of level should have been brought to your attention by someone at the Hospital?

A. I think my answer would be the same. I would not fault anybody for not having done so.

Q. Had it been brought to your attention, or if this kind of level was brought to your attention today, would you look into the possibility of digoxin intoxication?

A. Today is an entirely different thing. We are doing routine digoxin levels. We were asked by the Chief Coroner to do that, right from the weekend of the 21st/22nd of March, 1981. So it would be done.

Q. It would be done today?

A. Yes.

Q. If they were not being done routinely and it was brought to your attention that the level was 3.7 --

THE COMMISSIONER: It would depend of course a great deal on when it was taken, would it not - the 17th of December at 4:30, and the child died at --

MR. LABOW: 3:20 on the 18th.





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THE COMMISSIONER: You have to give him all of the facts and then see whether he would --

THE WITNESS: Should I answer that question, then? I will answer it in this way. In the first place the discharge reports are not available at the time of autopsy.

MR. LABOW: Q. Right.

A. So the residents would not have this information.

Secondly it says that the digoxin level was 3.9 and they were holding digoxin so presumably it would be ~~falling~~ falling, and the child was still - he was alive. I would not have thought that digoxin in this case would have been a factor in causing the death.

Q. So you would not have looked into it?

A. I would not personally have.

Q. Correct me if I am wrong, but my understanding of the situation is, if the clinical record or the clinician do not present that kind of diagnosis, possible digoxin intoxication, to the pathology people, it is not something that they would look into.

A. We would not focus on that







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sort of information.

MR. LABOW: Thank you. I have no further questions.

THE COMMISSIONER: Thank you.  
Mr. Shinehoft.

CROSS-EXAMINATION BY MR. SHINEHOFT:

Q. Doctor, we are going to be hearing from Dr. Cutz shortly, but could you tell me the position of Dr. Cutz at March of 1981?

A. Yes. He was a senior staff pathologist in the Pathology Department of Sick Children's.

Q. So he would have a similar position as you had at that time?

A. Similar, yes.

Q. Would the difference between your job and his job be the area of sub-speciality or would you both be doing the same things, basically?

A. No, we handled different types of cases in a sub-specialized way.

Q. You have given evidence that Dr. Cutz came and saw you some time in March and you had a conversation about the digoxin level of





B-4

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this baby, Pacsai. Is that correct?

3

A. That is correct.

4

Q. Do you recall the specific  
date that this happened?

5

A. This was the 20th of March.

6

7

Q. This was after he had  
performed a coroner's autopsy. Is that correct?

8

A. That is correct.

9

10

Q. Do you recall that  
conversation that you had with Dr. Cutz?

11

A. Yes, I do.

12

Q. And was it just the digoxin  
level that was discussed between you and he?

13

14

A. There was more to it than  
that. The possibility that it might be therapeutic  
error was discussed.

15

16

Q. Let me ask you some specific  
questions about the meeting. For example, was the  
anatomical findings at the post mortem discussed?

18

19

A. No - I don't think in any  
great extent.

20

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Q. Did he tell you that the  
baby had a perfectly normal heart, on autopsy? Did  
he mention that to you?

22

23

A. I cannot recall.

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Q. Did he discuss, in his opinion,  
what the cause of death was of this baby?

A. I cannot recall.

Q. Did he tell you why he took  
a post mortem sample of digoxin?

A. I think so.

Q. And why was that?

A. I think because of the  
question of digoxin toxicity.

Q. I'm sorry?

A. I think because of the  
question of digoxin toxicity.

Q. I believe you just told Mr.  
Labow that digoxin toxicity does not have any  
specific clinical symptoms. Did I misinterpret  
what you said to him?

A. No --

THE COMMISSIONER: Clinical symptoms?  
You mean pathological?

MR. SHINEHOFT: Q. Pathological -  
any findings?

A. There are not findings,  
clinically, to my knowledge, that absolutely  
indicate that this person has digoxin toxicity.  
Those findings could be related to other things, too.





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Q. Right, so the only way you could really be sure is if you did a post mortem - or level to ascertain what the value would be. Is that correct?

A. Yes, at our point of investigation, that would be the only way we could.

Q. So you are saying that Dr. Cutz was suspicious and that is why he took the sample?

A. Yes, that is my understanding.

Q. Would you agree that once you heard about the reading of this baby, that was sort of the piece of the puzzle that put everything together?

A. Well, once I heard about the startlingly high results in Pacsai, then the startlingly high results, even much higher, three times approximately, in Estrella took on a new meaning, a new importance.

Q. It rang a bell?

A. Correct.

Q. Have you ever heard of the condition which is known as transient hypofunction of the adrenal cortex?

A. Not specifically.





Mancer, cr.ex.  
(Shinehoft)

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Q. That is a pretty specific question, Doctor.

A. I can understand from --

THE COMMISSIONER: I take it you are not an expert in it, in any event?

MR. SHINEHOFT: Q. Well, I do not know, Dr. Becker seems to think that you are because in Volume 40, page 7985, line 21, it gives an answer, when I asked him that question:

"Well, I'm not sure if it is an area of expertise but I know some of the members, for example, Dr. Mancer has written on this subject."

He is attributing to you some expertise, Doctor.

MR. SCOTT: Dr. Becker's evidence would hardly make Dr. Mancer an expert.

MR. SHINEHOFT: Q. No, I just wanted to ask you --

THE COMMISSIONER: He can answer you if he has written on the subject. Have you written on some subjects?

THE WITNESS: Well, yes.

THE COMMISSIONER: Akin to that?







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THE WITNESS: Congenital adrenal hypoplasia I think is what Dr. Becker is referring to. That is not quite the same as the terminology you used. It would not have the same meaning to me.

MR. SHINEHOFT: Q. I understand. I understand those are two different things, really, but you have heard of that particular condition that I referred to, have you not, Doctor?

A. Not in the term that you put it.

THE COMMISSIONER: Transient hypofunction of the adrenal cortex, what is the subject that you have written about?

THE WITNESS: Congenital adrenal hypoplasia.

THE COMMISSIONER: Could you tell us - hypo -

THE WITNESS: Hypoplasia means essentially small adrenal cortex.

MR. SHINEHOFT: Q. Would you agree with me, Doctor, that the condition of transient adrenal insufficiency and transient hypofunction of the adrenal cortex are one and the same, are descriptive of the same condition?

A. That term that you used,





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transient, to my knowledge, in the cases that I have written about, there was nothing transient about those.

THE COMMISSIONER: That is taken from what, Mr. Shinehoft?

MR. SHINEHOFT: Transient adrenal insufficiency is taken from the Bain report, Mr. Commissioner.

THE COMMISSIONER: Let us refer to the Bain report then.

MR. SHINEHOFT: Page 27.

MS. CRONK: It is Exhibit 48.

THE COMMISSIONER: What page in the Bain report?

MR. SHINEHOFT: Page 27, Mr. Commissioner, about two-thirds from the bottom.

Q. If I could just maybe ask you one or two preliminary questions about the Bain report before I ask you specifically --

THE COMMISSIONER: Let him just read that.

THE WITNESS: What page is that?

MR. SHINEHOFT: Page 27.

THE COMMISSIONER: I think you might read it and tell us if that is the same disease that





1  
2 you have written about.

3 THE WITNESS: No, that is not the  
4 same condition that I wrote about.

5 MR. SHINEHOFT: Q. That is not the  
6 same condition that you wrote about? My next  
7 question is, is transient adrenal insufficiency one and  
8 /the same as transient hypofunction of the adrenal cortex,  
9 or do you know?

10 A. It possibly is. I do not  
11 really know.

12 Q. I take it, Doctor, that one  
13 of your areas of interest, since you have written  
14 about it, is endocrinology, the pathology of  
15 endocrinology?

16 A. I have written a little bit  
17 about that in connection with that adrenal paper,  
18 yes, but endocrinology is not really a major interest  
19 of mine.  
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Q. But you have written papers on the subject, have you not?

A. I have contributed to papers on problems that touch on endocrinology.

Q. And would it be fair to say that you have never heard of transient adrenal insufficiency?

A. Yes, it would.

Q. Okay.

A. As a specific disease, I have never heard of it. I can understand what it means.

Q. You have never heard of it?

A. As a specific disease entity, I have never heard of it.

Q. Obviously, it flows from that that you have never had a pathological diagnosis of this disease, since you have never heard of it?

A. That would not ordinarily be a pathological -- That sort of a diagnosis would not ordinarily be a pathological diagnosis; it would be a clinical --

THE COMMISSIONER: Dr. Bain seems to indicate that there were no findings; that is why





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C2 2 it is transient. It has been and it has gone. Isn't  
3 that the purpose -- Isn't that what "transient" means?  
4 MR. SHINEHOFT: Yes, I believe so,  
5 Mr. Commissioner.  
6 So, you wouldn't find it  
7 if it is transient?  
8 Well, that is  
9 what Dr. Bain says. There may be other doctors that  
10 say something different.  
11 THE COMMISSIONER: Well, if it is  
12 transient, you wouldn't find it, I would think.  
13 Isn't that the purpose?  
14 MR. SHINEHOFT: Well, that is  
15 what Dr. Bain implies, but I would suggest, before  
16 you --  
17 THE COMMISSIONER: I don't want  
18 to argue with either you or Dr. Bain at the moment;  
19 I am just talking about what it means.  
20 MR. SHINEHOFT: It means it was  
21 there and gone, but it doesn't necessarily mean that  
22 it hasn't left something behind.  
23 THE COMMISSIONER: Oh, I see.  
24 Okay.  
25 At any rate, you don't know any-  
thing about it.





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MR. SHINEHOFT: Q. You wouldn't care to engage in any further discussion about this?

A. I have had no experience. I wish I could enlighten you on it.

Q. Just one or two more questions, doctor.

You discussed with one of the examiners the question of the multiple effect and the issue or question of pre and ante mortem, or ante and post mortem levels of digoxin. You said at one time that you thought they were the same; that an ante mortem and a post mortem reading would be the same. Then, you further went on to state that we now know differently.

Have I correctly paraphrased your evidence?

A. That is correct.

Q. Do you know for a fact, and has it been proven --

THE COMMISSIONER: The answer to that is, no, he does not know for a fact; it is not his field --

MR. SHINEHOFT: Q. You say Dr. Phillips has the data?

THE COMMISSIONER: I don't know







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for a fact either. That is one of the matters we are going to investigate with a pharmacologist.

MR. SHINEHOFT: Q. Would it be fair to say, doctor, that you would defer to the opinion of the pharamacologists and, if it were shown that there is no such thing as a multiplier effect, that you would have to agree with that?

A. I haven't really, I don't think, in the course of being a witness here, talked about the multiplier effect. I remember a question was put to me which I could not answer.

Q. Very specifically, you did answer a question, and I think I have quoted your exact words: "We now know differently."

Although you went on to say further that: "Dr. Phillips has this data."

On further questioning, you said that he used Exhibit 202B as the guideline for accumulation of this data.

Is that not correct, doctor?

A. That was obtained through the use of that protocol I designed with the help of others. I believe that data went back to Dr. Phillips. I think it was accumulated by Mr. Cimbura, and that is really as far as I am prepared to go on it.





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Q. Dealing specifically with Baby Kevin Pacsai, doctor, other than your meeting with Dr. Cutz and the discussion that you had with him about the dig. levels, have you had any other involvement with this baby? I know you spoke to Dr. Tepperman but, other than that, have you had any other dealings?

A. We have had meetings in our Department among the pathologists that were involved and, among other cases, we probably discussed this one.

Q. Did you ever discuss this case with Dr. Bain?

A. No.

MR. SHINEHOFT: I have no other questions. Thank you very much, doctor.

THE COMMISSIONER: Thank you.

Mr. Scott?

RE-EXAMINATION BY MR. SCOTT:

Q. Dr. Mancer, as you dealt with it last, let's talk about the protocol.

I take it the purpose of the protocol was to provide a control, in effect, to what happened in the Estrella case?

A. Yes, that is correct.





Mancer  
re.ex. (Scott)

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Q. And as part of the control, you were interested to see whether the Estrella results are duplicated - and I use that in the broad sense - or not?

A. Well, it is to see whether the Estrella results are reliable or how reliable they are.

Q. Very well.

Now, Dr. Phillips is the custodian of those results at the moment, at the Hospital at least.

A. At the Hospital.

Q. Can you tell us what those results, in a general sense, revealed?

MR. LAMEK: Well, Mr. Commissioner, this is a matter which I avoided because Dr. Mancer has no specific knowledge, and general knowledge is going to be thoroughly misleading, with respect, until we get to the details.

THE COMMISSIONER: For what purpose do you want this?

MR. SCOTT: Well, Dr. Phillips is not on the list of Commission Counsel witnesses, insofar as I know anyway.

MR. LAMEK: Yes, he is.







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MR. SCOTT: They haven't interviewed him with this in mind.

MS. CRONK: At the time that Dr. Ellis and Dr. Soldin testified, we made it clear that he would be called on this very issue.

MR. SCOTT: Then I need not trouble you any further about it, Dr. Mancer. Thank you very much. I just like to get these things nailed down. We will be hearing about that in due course in an accurate way, so you will not have to attempt to summarize it for me.

Q. Now, I gather, when I was absent - I just turn up for the re-examinations -- I gather, when I was absent, you discussed with some of the counsel present the method by which a leg vein would be milked?

A. Yes.

Q. And I take it that the problem that presents itself is that, when the pumping action of the heart is stopped, the blood lies in the vein; it is not being moved to any significant extent?

A. Yes. Except that if, after the vein is cut at the level of the pelvis --

Q. There is some force of





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gravity?

A. Well, some would leak out.

Q. Yes. But it is not moving  
as it would be in a living body?

A. Yes.

Q. And that one of the pur-  
poses of milking is to bring the blood in the vein  
either up or down to the point of exit --

A. That is correct.

Q. -- that the cut represents?

A. That is correct.

Q. And, in the milking  
process, it is important to know whether there is  
edema in the area of the vein?

A. That is correct.

Q. Because the edema is a  
bruising or wound of some type in which liquid has  
collected around the cells?

A. I wouldn't call it a  
bruise or a wound. You see, there is normally fluid  
around cells and outside of blood vessels --

Q. Yes.

A. -- in all parts of our  
body.

Q. Would it fair to say that,





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in the case of edema, there is likely to be more  
liquid?

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A.. That is correct.

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Q. And the risk is that, in  
squeezing the edema fluid, or the fluid that is  
present, the edema will enter the vein and move down  
to the cut?

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A. No, I don't think that  
is the way it happens.

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Q. Well, will you tell me  
how it happens?

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A. Well, my impression of  
what would happen during the milking process is that,  
as well as blood being squeezed along the vessel,  
edema fluid is being squeezed outside the vessel but  
up higher in the leg --

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Q. Yes.

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A. -- so that, when -- at  
the area of collection, because one is using a  
receptacle to collect at the vein level, as well as  
simply blood flowing into the receptacle, there would  
also be some material from around the vein and,  
unless you got the vein itself and nothing else - but  
that is unlikely using a receptacle --

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Q. So that, in a case where







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there is edema at the point of collection, the blood is likely to be contaminated by the edema fluid?

A. That is correct.

Q. And one of the important things to know, when you are milking presumably and when you want to determine the purity of your sample, is whether there is evidence of edema that might contaminate the fluid, the blood?

A. Well, I think that, in that case, the more edema, the more likely there is to be contamination.

But I think, even if there was no edema, there would still be some of this fluid coming down?

Q. Well, I take off there, from your statement, that the more edema, the more likely there is to be contamination. When you referred in this connection to page 11 of the Estrella record, which is the final autopsy report -- do you have that in front of you?

A. No, I do not.

Q. Perhaps I can show you mine. Do you have a copy of it?

A. I don't have a copy here.

Q. Let me show you mine.





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It is page 11 of the record and it is the last paragraph, and I would ask you to read to yourself the fourth sentence beginning from "There were manifestations...".

A. Yes.

Q. Now, that refers to interstitial edema, is that right?

A. That is correct.

Q. So, do we know from that that the record in this baby revealed positively the presence of interstitial edema?

A. Yes.

Q. And therefore I take it that, in the milking process, the risk of contamination is greater rather than less?

A. Yes.

THE COMMISSIONER: I'm sorry, interstitial? I have been through this before. It is between what?

THE WITNESS: Between the cells and the blood vessels.

THE COMMISSIONER: Does it tell you where this edema was?

THE WITNESS: I don't believe it does in that sentence. I think it implies that it is





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generalized.

THE COMMISSIONER: It would be in  
the legs?

THE WITNESS: Yes.

THE COMMISSIONER: If it were not  
in the legs, would it have any effect?

THE WITNESS: Pardon me?

THE COMMISSIONER: If it were not  
in the legs, would it have any effect?

THE WITNESS: Well --

MR. SCOTT: On the milking process?

THE COMMISSIONER: That is what  
I meant, yes. We are talking about the milking process.

THE WITNESS: If it were not in  
the legs, it would not have any greater effect than  
it would in the normal person's leg being milked.

THE COMMISSIONER: But I under-  
stand -- But you said there would be foreign material  
come anyway with the milking process.

THE WITNESS: With any individual.

THE COMMISSIONER: We are talking  
about the edema.

THE WITNESS: Yes.

THE COMMISSIONER: Do we know  
whether this interstitial edema --







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MR. SCOTT: I think perhaps I can find out.

THE COMMISSIONER: Can we find out where that is?

MR. SCOTT: I think I can.

Q. I take it, doctor, that interstitial edema typically is concurrent with, or results from, congestive heart failure?

A. That is correct.

Q. So that, if you had a baby with congestive heart failure, no matter how caused, and interstitial edema, that interstitial edema would be general throughout the body in the normal case?

A. That is correct.

Q. So that, if it appears in the arm, it is going to appear in the leg?

A. Yes, that is right.

Q. And would it be a fair reading of this final autopsy report to conclude from it that the interstitial edema would be found, among other places, in the legs of the patient?

A. Yes.

Q. So that the chance of contamination by the process we have discussed is





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greater rather than lesser?

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A. Yes.

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MR. SCOTT: Does that help?

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THE COMMISSIONER: Yes. It solves  
that part of the problem.

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The next thing I want to know -  
and perhaps you are going into it - is what - and

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probably this poor witness is not qualified -  
it is contamination, but what kind of contamination  
so far as digoxin is concerned?

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Do you know anything about that?

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THE WITNESS: Well, at this point,  
I am aware that, since digoxin is high in muscle in  
a digoxin-treated patient and there would be a lot of  
muscles around the -- that would have been  
squeezed, in the area it would have been squeezed and,  
since the membranes of the muscles are likely to have  
broken down after death and released the digoxin into  
the interstitial fluid, then the interstitial fluid  
is likely to contain some digoxin and raise the level  
over what it would have been if the interstitial  
fluid did not contain digoxin.

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THE COMMISSIONER: Yes. All right.

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Thank you.

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Q. So that the level obtained is artificially high - I shouldn't say artificially high but it's higher than real life by this process?

A. Yes.

Q. Well now, one other question about this process. I take it from what you have told us that it appears in this case, and we will have Dr. Taylor's evidence on it, that after the autopsy was performed there is a washing process. That is performed by some kind of a hose, is it?

A. Yes.

Q. Water under pressure applied to the body, under some kind of pressure?

A. Well, not under great pressure.

Q. No.

A. Just flowing over the body.

Q. Yes, it isn't intended to be callous to say but you wash as you would wash an object?

A. That's correct.

Q. Yes, for the purposes of cleaning it?

A. Yes.

Q. And following that the body







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is moved to some kind of trolley for transportation to, what is it, the Hospital Morgue?

A. Yes. It depends on the size of the body, whether it is moved on a trolley or brought in a case that's hand carried.

Q. Well, it is then in due course moved to another part of the Hospital?

A. That's correct.

Q. And where is that part of the Hospital in relation to where the autopsy done, is it on the same floor?

A. No, it is in the service level which is - well, there is the service and then main, 1, 2 and 3.

Q. Yes.

A. We're on the third floor in pathology.

Q. And the body is therefore carried or by trolley moved along the corridors, down the elevators into the storage area?

A. That's correct.

Q. And then there is lifting and movement of the body in the course of this transportation as one might expect in the normal way?

A. That is correct.





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Q. Yes. And then I take it there is a containment facility in the storage area?

A. Yes, the bodies are kept there.

Q. Until removed?

A. Until removed, yes.

Q. Yes. We will hear, if we haven't heard already, that Dr. Taylor, after this had occurred with respect to the Estrella baby, went down to this storage area. Do you have any information as to whether he took the sample for the digoxin reading in the storage area or removed the body back upstairs?

A. I believe it was in the storage area.

Q. Yes, all right. Now, I suggest to you that after the washing process, or during and after the washing process water naturally collects not in the internal cavity and other parts of the body?

A. Well, some water may enter the body cavity.

Q. Yes.

A. Resulting from the washing of the body.





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Q. And no attempt is made to  
remove that?

A. No.

Q. No.

A. The body ---

Q. I'm sorry?

A. The body has been sutured up.

Q. Well, I understand that. But  
you are well aware that notwithstanding that, as a  
result of the washing process water will probably  
enter in small or perhaps occasional medium  
quantities the body cavity?

A. One would expect so.

Q. Yes, nothing surprising  
about that.

A. No.

Q. And I take it that in the  
course of this movement it is inevitable that the  
water that is retained in the cavity will remain in  
the cavity and slosh around, to use a callous  
expression. Isn't that fair?

A. Any fluid that's in the  
body would be ---

Q. I'm not talking about any  
fluid, I would just draw you to this case.





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A. Well, it would be a mixture of water and whatever else was there.

Q. Well, that's what I'm getting at. I take it that as a result of this sloshing process there is a mixture of liquids in the cavity and the mixing process goes on as the body is moved?

A. Yes.

Q. Yes. Now, the cut that is made routinely to get a leg serum is made at the top of the leg, is it not?

A. It depends on when the person is trying to obtain a blood sample from the individual.

Q. All right. Do you have any information as to where it was made in the Estrella case?

A. Well, my understanding is that the open end of the vein was the site of sampling.

Q. And would that be at the top of the leg?

A. It would be where the iliac vein comes from the leg into the pelvis.

Q. Well, that might be at the e







Mancer, re-ex.  
(Scott)

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2 of the ear lobe for all I know. I mean, where is it.  
3 I'm sorry Doctor, but I don't know.

4 A. You see, the area would be  
5 inside the body cavity after the pathology resident  
6 had identified the site of the cut vein and then he  
7 would put a receptacle at that site.

8 Q. Yes?

9 A. And then he and the doctor  
10 that was helping him together would raise the leg  
11 and then milk the ---

12 Q. Well, I don't want to come  
13 out of the milking yet. I take it that the cut is  
14 at or near or inside the body cavity?

15 A. Well, the cut would have  
16 been made much earlier.

17 Q. Well, I'm not talking about  
18 time. Well, maybe you are and that's fair. Is the  
19 cut, whenever it was made, inside the body cavity?

20 A. Yes.

21 Q. And I therefore take it that  
22 it would be exposed after the body was sewed up and  
23 moved to any sloshing liquids in the cavity?

24 A. Yes.

25 Q. So that not only is the  
liquid, not only is there a potential - I put it no





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higher than that - for contamination of the liquid in the cavity but that the liquid may contaminate the cut where the vein is severed?

A. That's correct.

THE COMMISSIONER: I'm getting a little confused. In the Estrella case was not some blood, one of the samples taken from what has been referred to as the pelvic cavity. Is that not right?

MR. SCOTT: Yes.

THE COMMISSIONER: It's the body cavity you're talking about?

THE WITNESS: Yes.

THE COMMISSIONER: All right. Well, there was another sample taken from the vein?

THE WITNESS: That's right.

THE COMMISSIONER: And that's where the milking took place?

THE WITNESS: Yes.

THE COMMISSIONER: But the vein itself is not the same thing. It is not in the pelvic cavity, is it?

THE WITNESS: Yes, the site of the vein, it leads to the pelvic cavity and the site of sample.





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THE COMMISSIONER: Yes, but where would he have taken the sample from. Would it be from somewhere in the vein, I took it, somewhere in the vein, I took it to be somewhere in the upper part of the leg.

THE WITNESS: Well, it is actually where the vein enters the pelvic cavity.

THE COMMISSIONER: Yes. But Mr. Scott has been asking you, and this is where I got confused, about mixture of fluids in the pelvic cavity.

MR. SCOTT: Well, Mr. Commissioner ---

THE COMMISSIONER: I may not be doing this ---

MR. SCOTT: Perhaps I can clear it up.

THE COMMISSIONER: All right, if you can. All right, go ahead, try it.

MR. SCOTT: The cut that is made in the leg is at the pelvic cavity, isn't it?

THE COMMISSIONER: It is where the vein joins the pelvic cavity?

MR. SCOTT: Yes.

THE COMMISSIONER: But whether that means the fluid in the pelvic cavity gets into the







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vein, does it, in some way?

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THE WITNESS: Well, I think Mr. Scott is trying to indicate that the area of collection is likely to have been contaminated by the fluid sloshing around in the pelvic cavity.

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THE COMMISSIONER: Yes, I am sure he is trying to establish that.

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MR. SCOTT: The question is am I succeeding.

THE COMMISSIONER: I don't know whether he's succeeding or not. We have two samples; one taken from the pelvic cavity itself, and that one we know that there is likely to be all sorts of other fluids in there.

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MR. SCOTT: I can't hear you, Mr. Commissioner.

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THE COMMISSIONER: Including water and anything else that happens to be passing through the pelvic cavity, but he has also taken some from the vein and you now tell me that the cut was there, probably made in the course of the autopsy.

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THE WITNESS: Early in the autopsy.

THE COMMISSIONER: Early in the autopsy and there was a cut there of the vein where





Mancer, re-ex.  
(Scott)

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it joins the pelvic cavity. Is that right?

THE WITNESS: Yes, it would be severed at that site.

THE COMMISSIONER: Yes. Well now, would the fluid that is in the pelvic cavity, would it get into that vein?

THE WITNESS: Well, it would to some extent, it would contaminate the area. Some may get into the vein, we don't really know but it's possible.

THE COMMISSIONER: Well, if there is a connection between the pelvic vein and pelvic cavity and the vein there is no question that it would, but if there is a cut there, I'm not sure that it would. Maybe you could tell me whether it would or not?

THE WITNESS: Well, the vein is severed at some point early in the autopsy. I mean, I think that at some point on the vein ---

THE COMMISSIONER: Once it is severed is there a likelihood or a possibility or any other noun you want to use of the contamination which may or may not be, probably is, in the pelvic cavity getting into that vein?

THE WITNESS: There is a possibility





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of that.

MR. SCOTT: Q. Well, even further than that, Doctor. I take it what you have is, you have a severed vein, which is like a small tube that has been cut across, isn't it?

A. Yes.

Q. And that severed vein is at the pelvic cavity?

A. Yes.

Q. And it remains there. It's not taken away, it remains there?

A. Yes.

Q. All right. Now, there is some blood lying in that vein after the body dies?

A. Yes.

Q. And it is the milking process that is designed to extract that into a collector at the mouth of the severed vein?

A. That's correct.

Q. Now, what I want to ask you is, in a case like Estrella with the cavity fluids and with the movement of the body and with all that we are going to hear about occurring, first of all, is there any contact, is there any realistic possibility of contact between the cavity fluid and





D-12

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the mouth of that vein?

3

A. Yes.

4

Q. Yes. Can that contact  
contaminate if the body fluids are contaminated?

5

A. Yes.

6

7

Q. All right. Now, the question  
that the Commissioner asked you goes further. Is  
there a possibility that some of the body fluids  
will actually enter the vein?

8

9

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A. There's a possibility, yes.

11

12

Q. And I take it that would  
produce, might produce contamination as well?

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Q. So, you have the interaction  
between the severed vein and the cavity fluids  
potentially producing two sources of contamination;  
one by entry of the fluid into the vein, the second  
by exposure of the cut of the vein to the body  
fluid?

19

A. Yes.

20

Q. Yes.

21

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23

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THE COMMISSIONER: But it will  
enter into the - I can understand the second one  
but I'm still having some trouble with the first one.  
When you cut a vein do you cut it completely? It is







D-13

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severed, isn't it?

3

THE WITNESS: Well, in this case

4

it is severed.

5

THE COMMISSIONER: All right. Now,

6

if it is severed is there a connection between the  
top and the bottom of this vein? Will things pass

7

from the top to the bottom. Remember, this

8

milking process comes from the bottom?

9

THE WITNESS: Well, there won't

10

be any connection any more because it is part of

11

the evisceration in which it is severed.

12

THE COMMISSIONER: All right.

13

MR. SCOTT: I've got another idea.

14

THE COMMISSIONER: Now, what I

15

would like to know is what sort of contamination  
can come from the pelvic cavity once the vein has

16

been severed if you take the blood only from the

17

bottom part of the vein. Do you follow me?

18

THE WITNESS: Yes.

19

THE COMMISSIONER: Presumably that's

20

why Dr. Taylor - well, no, first of all I think it  
was he couldn't get enough blood from the vein. I

21

assume, and we're going to hear from him next week,

22

but I assume that he went for the vein because he

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thought that would be purer, did he not?

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Mancer, re-ex.  
(Scott)

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THE WITNESS: Yes.

THE COMMISSIONER: Than going to  
the pelvic cavity for blood?

THE WITNESS: Yes.

THE COMMISSIONER: So, he went to  
the vein where he presumed ... Now, whether he  
wanted to or not it may well be that there is, and  
if you can't put it any higher than a possibility  
that's fine but I want to know if there is a  
possibility, is there a possibility that once the  
vein has been severed it will still be the  
contamination from the pelvic cavity getting into  
the lower part of that vein from which he took the  
blood?

THE WITNESS: There is a possibility.

THE COMMISSIONER: All right,  
that's fine.

MR. SCOTT: Q. Well, isn't it,  
Doctor, a dual possibility. First of all, is entry  
of the contaminated fluid into the vein, which you  
have described, and then exposure of the end of the  
vein, its mouth, where it has been cut to the  
contaminated fluid?

THE COMMISSIONER: But to what  
contaminated ---





Mancer, re-ex.  
(Scott)

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MR. SCOTT: Well, but now ---

THE COMMISSIONER: Yes, all right.

MR. SCOTT: The gutter fluid in  
the stomach.

THE COMMISSIONER: But isn't that  
the same thing?

MR. SCOTT: Yes, but there are two -  
I think the Doctor has just told us that there are  
two potential sources of contamination; first, when  
the fluid enters the vein, if it does, and secondly  
by contaminating the mouth of the vein out of  
which the blood will later be extracted. Have I  
got that right, Doctor?

THE WITNESS: Yes.

MR. SCOTT: Q. If I can put you  
to this example. If you imagined the vein as  
being a milk bottle with a mouth at the end which  
you have made by cutting it. Are you with me so  
far?

A. Yes.

Q. The milk bottle is full of  
milk just as the vein may have blood in it. A  
contamination for these purposes is a poison. I  
don't use poison in the generic sense, it is the  
presence of something at a place that you don't want.







Mancer, re-ex.  
(Scott)

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Right?

A. Right.

Q. All right. Now, I put it to you that if you ring the mouth of the milk bottle with poison or with a contaminated substance you would not necessarily contaminate the milk in the bottle, would you?

A. That's right.

Q. But you would contaminate the milk, or run a real risk of contaminating the milk when you pour the milk from the bottle and force it to over the contaminated area?

A. Yes.

Q. And is that what we're talking about as one of the sources of contamination of the substance in the vein?

A. Yes.

Q. Thank you.

I don't know if that helped.

THE COMMISSIONER: Well, I could go on forever I suppose. Why would the vein be contaminated at the point where it's cut?

MR. SCOTT: Because of the gutter -- well, I shouldn't ---

THE COMMISSIONER: Well, no, I can





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understand that, but you keep talking about two sources and the only source I can think of is the vein is connected with a pelvic cavity. At some point what was in the pelvic cavity would pass to the vein, either to the top or right down to the vein.

MR. SCOTT: It's right there, it's right there.

THE COMMISSIONER: Or anywhere. If it's right there there is no problem but once you cut the vein ---

MR. SCOTT: It's still right there.

THE COMMISSIONER: Well, it is still right there but I just asked. I was asking, he gave me the answer that there is a possibility once you cut the vein that you can still get contamination from the pelvic cavity, it can still go into the ---

MR. SCOTT: Well, let me go at it again.

THE COMMISSIONER: Yes. But I don't understand where this poison analogy that you are talking about on the top of the milk bottle comes in.

MR. SCOTT: Q. Well, let me ask





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you to assume, Doctor, for the moment that gutter  
fluid is contaminated. I ask you to assume that.  
Are you with me?

A. Yes.

Q. All right. Now, we're  
talking about getting blood from an inert vein. I  
think inert is perhaps the right word, is it?

A. Yes.

Q. Non-living vein.

A. Yes.

Q. And you have told us about  
the possible contamination from the edema, the  
interstitial fluids in the leg?

A. Yes.

Q. And that's one source of  
contamination?

A. Yes.

Q. What you get out may be  
contaminated?

A. Yes.

Q. All right. Now, let's deal  
with something ---

THE COMMISSIONER: Was that the  
poison that you're talking about at the top of the  
milk bottle?





D-19

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MR. SCOTT: No.

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THE COMMISSIONER: Oh.

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MR. SCOTT: That's one source of contamination which comes from the interstitial edema fluid in the leg. Now, let's leave that aside because I want to see if there are other sources of contamination.

8

9

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11

Q. You have told the Commissioner, and tell me if I misunderstand this, but the mouth of the vein is exposed to the contaminated fluid in the body cavity?

12

A. Yes, that's correct.

13

14

15

Q. All right. Now, what I'm asking you is, does that exposure raise the potentiality of contamination for anything that comes out of the vein in the milking process?

16

A. Yes.

17

18

19

20

Q. Now, I have suggested to you that that risk of that kind of contamination is twofold: one, as the Commissioner has asked you because some of the cavity fluid may leak into the vein. Is that not right?

21

A. That's possible.

22

23

24

25

Q. And the second because the mouth of the vein over which the blood must pass as







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it is collected will become contaminated by its  
physical contact with the gutter fluid. Is that  
fair?

4

5

A. Yes. It's not just the  
mouth of the vein though but the area around the  
mouth.

6

7

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THE COMMISSIONER: I would have  
thought it was the vein itself. I will accept  
your two. I still have a feeling it is really just  
one made doubly good by your examination. The  
problem is, this mouth and the vein itself, both  
the mouth plus the vein are subject to  
contamination.

13

14

MR. SCOTT: Yes.

15

16

THE COMMISSIONER: Yes.

MR. SCOTT: There are three  
sources of contamination.

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THE COMMISSIONER: Well, yes.

MR. SCOTT: One is the actual  
material as it comes down by the interstitial fluid,  
the second is the actual material comes down  
affected by some liquid that has leaked in and the  
third is the actual material which comes down and  
until it gets to the very mouth let us assume it  
is perfectly pure and then it passes over a





D-21

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contaminated surface. Is that a fair statement,

3

Doctor?

4

A. Yes.

5

6

7

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Q. Now, the reason I got into all of this is because your protocol, and I don't say this disparagingly, it is obviously an excellent protocol, it overlooks the possibility for that process?

9

A. Yes.

10

11

Q. In other words, in your protocol you simply have one stage at which the samples are taken?

12

13

A. Yes.

14

Q. And they are taken in the sequence that you have outlined in the protocol?

15

A. Yes.

16

17

18

19

Q. Yes. In the Estrella case we know that that sequence was broken by a series of events that occupied somewhere from one to three hours.

20

THE COMMISSIONER: I thought that was what the protocol was doing.

21

22

MR. LAMEK: Three hours after autopsy.

23

MR. SCOTT: All right.

24

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THE COMMISSIONER: Protocol does it again three hours later.





Mancer, re.ex.  
(Scott)

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MR. SCOTT: That is true, that is true.

Q. Does the protocol establish any control parallel for the sloshing of gutter liquid in the body?

A. No.

THE COMMISSIONER: Why not? There is a three hour period.

THE WITNESS: There is a three hour period but the body would not be moved from the autopsy table. It would not have been brought down to the morgue in the various movements that have been described.

Q. Let me ask you this, Doctor. In the protocol, when the three hour gap, which I overlooked, when that three hour gap is occurring, is it the intention of the protocol that before that three hour period the body will be stitched up?

A. No, that was not done either.

Q. Is it the intention of the protocol that the body will be washed?

A. It was not done either.

Q. Is it the intention of the protocol that the body will be moved in the way you you described so as to effect sloshing?







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A. It was not the intention, no.

3

Q. I do not criticize the

4

protocol because we all work as best we can from

5

day to day, but would you agree with me that those

6

are three matters that were overlooked in the protocol

7

if you were trying to seek a precise control for the

Estrella results?

8

A. They are not in the protocol.

9

Q. And therefore the Estrella

10

results, whatever they are, and Mr. Lamek does not

11

want me to tip anybody off, whatever they are --

12

sorry, Mr. Lamek (he is offended by that).

13

MR. LAMEK: It was an offensive  
remark.

14

MR. SCOTT: I am sorry, I did not  
mean to be offensive. It is Thursday.

16

THE COMMISSIONER: It probably was  
not intended, but I will tell you that what I am  
worried about in all of this is 202A and 202B went  
in back when Mr. Lamek was examining in chief. You  
came on after that, without any of this cross-  
examination. I don't know where the other counsel -  
they are all going to start screaming. You are now  
establishing that the protocol is not up to much.

21

22

23

MR. SCOTT: No, no.

24

25





1  
2 THE COMMISSIONER: Well, it is up to  
3 something, but it is not perfect.

4 MR. SCOTT: I just have one other  
5 question.

6 THE COMMISSIONER: That causes a  
7 problem. Mr. Lamek is still available, but no one  
8 else is, to deal with it.

9 I think it is only fair that you go  
10 first and you go last, but you go last for the  
11 purpose of dealing with things that have been dealt  
12 with by the other counsel. When you have a new  
13 thought like that, and I would not be a bit surprised  
14 if one of your learned advisors has prompted you with  
15 this one somewhere ---

16 MR. SCOTT: Especially as I was not  
17 here.

18 THE COMMISSIONER: Somewhere along  
19 the line, and it is not fair. I am not so worried  
20 about it because Dr. Phillips is coming and there  
21 are going to be all sorts of other people who can  
22 be cross-examined, but it is a little unfair, not  
23 deliberately, but in the result.

24 MR. SCOTT: I think you're quite right,  
25 Mr. Commissioner. I submit to that. I had intended  
to conduct my other examinations on entirely that





4 2 basis.

3 The only way, however, to assure that  
4 it does not happen from time to time is to prohibit  
5 the development of new thoughts, and I'm doing my best  
6 to encourage that, in my case and in everyone else's,  
7 but every once in a while ---

8 THE COMMISSIONER: To encourage early  
9 thought is what I am after, not to prohibit any  
10 thoughts.

11 MR. SCOTT: I understand. I will  
12 stop. I won't pursue it, but we may have to have  
13 Dr. Mancer back, but I will not pursue it now.

14 THE COMMISSIONER: Wait a minute.  
15 I don't want poor Dr. Mancer to be under this threat  
16 for the rest of his life. Why do you want to have  
17 him back?

18 MR. SCOTT: My friend tells me that  
19 he is going to put in the results, and I think that  
20 is fair. He has undertaken to do that. I think it  
21 is important to know the way they should be read and  
22 I think there is something to be learned from Dr.  
23 Mancer on that.

24 It may be that Dr. Phillips will  
25 explain it all for us, so I am not saying that Dr.  
Mancer will have to come back. He will certainly





1  
2 have to come back on Phase II.

3 THE COMMISSIONER: Of course, I  
4 forget I cannot stop you from bringing him back.  
5 He is your own client.

6 MR. SCOTT: The slightest hint of  
7 disapproval will do the job. I won't pursue it.

8 THE COMMISSIONER: I don't want you  
9 to not pursue it now because you have a present  
10 intention of pursuing it later, that is all.

11 MR. SCOTT: May I ask one more  
12 question and run the risk that my friends will want  
13 to add some others.

14 THE COMMISSIONER: Yes.

15 MR. SCOTT: Q. Dr. Mancer, do you  
16 remember where we were about the protocol.

17 Is there a risk that the control  
18 results from the protocol may be affected by the  
19 contaminations of the three types - or achieved in  
20 the three ways we have discussed this morning?

21 A. Yes, I think there is.

22 Q. Just one other matter, I  
23 think - two other matters.

24 When Mr. Percival, and this is real  
25 re-examination, when Mr. Percival at Volume 41, page  
8258 asked you at line 5, and he was speaking of the







1  
2 Estrella record, and he asked you:

3 "Q. And did you notice that there was  
4 anything strange or unusual about the  
5 medical records that then existed on  
6 Janice Estrella at that moment in  
7 time?"

8 I emphasize "at that moment in time".

9 You answered:

10 "A. Yes. I noticed that there was,  
11 at least it seemed to me that there  
12 was some data missing, some page  
13 missing possibly."

14 Now, I take it that Miss Symes has  
15 taken you through that in some detail, am I right?

16 A. Yes.

17 Q. I take it that you have had  
18 occasion to examine the hospital record for Janice  
19 Estrella?

20 A. Yes.

21 Q. What I am asking you is, are  
22 you now satisfied that the record is complete?

23 THE COMMISSIONER: It is more than  
24 that. Are you now satisfied that it was complete?

25 MR. SCOTT: Q. That it was complete  
at the time?





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A. Yes.

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Q. Thank you.

4

Now, just one other matter as a result of Mr. Tobias' examination when he asked you some questions about the Hines baby, and perhaps this is clear, but I just want to be certain.

5

6

7

When you participated in preparing Exhibit 198 - do you have that in front of you?

8

9

A. Yes.

10

11

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14

Q. I think you have told me, I just want to see whether anything has changed, that the diagnosis with respect to Hines "Crib death Bradycardia" was, as you recall it, the reading you made of the autopsy report in the Hines case.

15

16

17

A. Yes; I'm not sure as I stated before whether it was Dr. Cutz or I who made a judgment on that.

18

Q. It was one of you?

19

A. One of us did, and I was answering as if it was me that did.

20

21

THE COMMISSIONER: Whose writing is that? Is that yours?

22

23

THE WITNESS: That is his but that does not mean anything in the sense, because this -

24

25





1  
2 Dr. Cutz had to write over the previous writing.

3 Q. Could I just tell the  
4 Commissioner what happened, to shorten it up. It  
5 is a long explanation, and perhaps I can tell you and  
6 the witness can tell us if it is right, but this  
7 document was originally prepared in pencil and  
photocopied. Is that correct?

8 A. Yes.

9 Q. The writing of both Dr. Cutz  
10 and you appeared in pencil on the original?

11 A. I believe that to be the  
12 case.

13 Q. You did the writing at the  
14 top of the page, for example?

15 A. Yes.

16 Q. It was then photocopied with  
17 the intention of distributing it to whoever was  
entitled to have it. Is that right?

18 A. With the intention of  
19 distributing it at the meeting of the 25th.

20 Q. If it was distributed then  
21 it was recalled?

22 A. Yes.

23 Q. But when you had photocopied  
24 it, it did not come out clearly?  
25







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A. Yes.

3

Q. So that Dr. Cutz sat down and

4

wrote over on the photostat --

5

A. No, no, on the original.

6

Q. On the original?

7

A. That was all done before

photocopying.

8

Q. I am sorry, I had it wrong.

9

A. Because the first photocopies

10

were illegible.

11

Q. That is what I am saying.

12

The first photocopies were illegible, so what Dr.

13

Cutz did, he sat down and he wrote over his own

14

writing and he wrote over yours with respect to

diagnoses and cause of death?

15

A. That is my understanding.

16

THE COMMISSIONER: He did not change

17

it, I take it? He did not change any - or did he?

18

THE WITNESS: I am sure he did not.

19

THE COMMISSIONER: No, I am not

suggesting there was anything improper, but if he

20

reached any different conclusions that might be

21

important.

22

THE WITNESS: No, he would have written

23

over it simply to make the photostats legible.

24

25





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MR. SCOTT: Q. So you cannot even  
ask a simple question, whose handwriting is this.

3

4

I take it on this document it is  
Dr. Cutz' handwriting but in some cases he is simply  
copying over, for legibility, what you yourself wrote  
in your own hand?

5

6

7

A. That is correct.

8

9

Q. Now, back to Hines, in Hines  
you or Dr. Cutz took the diagnosis as an attempt  
to summarize the autopsy report?

10

11

A. Yes.

12

Q. And I take it when you came  
to cause of death you had before you the autopsy  
report?

13

14

A. Yes.

15

Q. And the record?

16

A. No.

17

Q. Just the autopsy report?

18

A. Yes.

19

Q. Now I take it it would be  
from the autopsy report, it would be the autopsy  
report to which you would refer if there were no  
new facts for the cause of death?

20

21

22

A. Yes.

23

Q. Now, the new facts in this

24

25





1  
2 case were the digoxin readings in Pacsai, Miller and  
3 Cook.

4 A. That was the new facts, yes.

5 Q. And you took those into account  
6 when you determined that the Hines baby's cause of  
7 death was undetermined?

8 A. Yes.

9 MR. SCOTT: Those are all the  
10 questions I have, thank you, Dr. Mancer. I hope I  
11 have not exposed you to a complete new round from  
12 everybody. You would never forgive me for that.

13 THE COMMISSIONER: Miss Chown.

14 CROSS-EXAMINATION BY MS. CHOWN:

15 Q. Dr. Mancer, I want to deal  
16 with two areas with you. First, there are some  
17 questions that were put to you by Mr. Hunt yesterday  
18 when he was asking you about the preparation of  
19 Exhibit 198 and he suggested to you at Volume 41,  
20 page 8253 that you were, in preparing Exhibit 198,  
21 going through a somewhat different process than you  
22 usually do as a pathologist, and the words that he  
23 used at line 13 were:

24 "... you had stepped out of that  
25 narrow role of examining each one..."

That is each case:

"...only within the parameters of that





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"particular child, and you were now  
assessing combinations of factors  
relating to more than one child in  
coming to your decision?"

Your answer - that is really part of  
his question - was, "Yes". That is what you were  
doing.

I would like to expand on that a little  
bit if I might today. I presume you would agree that  
in your ordinary day to day course of operations as  
a pathologist perhaps you would not describe it as  
narrow as Mr. Hunt did, but your role is to examine  
a particular patient and to draw some conclusions,  
if possible, about the cause of death. Is that  
correct?

A. Yes.

Q. I take it that you do  
autopsies, you and all the other pathologists in the  
Department, from all parts of the Hospital?

A. We supervise autopsies from  
all parts of the Hospital.

Q. And the cases that you do,  
or the residents do under your supervision, come in  
no particular order. They are simply assigned to  
you the days that you would be available to actually







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do an autopsy or supervise one?

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A. Yes.

4

Q. When you or your resident has

5

completed the autopsy itself and the final report

6

has been completed, that in effect is the end of that

7

particular case, subject, of course, to any discussions

8

that might be had of particular interesting cases

9

at the Pathology review meetings?

10

A. Yes, or any other meetings

11

that may take place with other divisions in the

12

Hospital.

13

Q. I take it that those meetings

14

would once again focus on cases that had aspects

15

of particular interest, either to the pathologist

16

or to other departments?

17

A. Yes.

18

Q. Am I correct in assuming

19

that it is not the general practice of the pathologists

20

in the department to informally or formally discuss

21

each and every case with each other?

22

A. At that time it was not.

23

Q. Right. Am I also correct

24

in assuming that it is not the practice of you and

25

the other pathologists in the department to be

keeping an eye out, if you will, for common





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characteristics as between cases?

A. That is correct.

Q. - at that time again, and I presume as well it is not your practice, in not observing those things, it is not your practice to keep any statistics or examples of trends?

A. That is correct.

Q. And would I be correct in saying in the autopsies that you personally participated in or supervised, during the period that is under discussion today, there was nothing particularly unusual in the autopsy findings that led you to come to any concern about the involvement of digoxin at the time those autopsies were performed?

A. That is correct.

Q. And it was really in this situation, after your discussions with Dr. Tepperman and at the time that you were preparing Exhibit 198, that with the suggestion and new information of the digoxin levels that had come to your attention, that you began, with hindsight, to look back at the cases?

A. Yes. We as a department looked back at the cases.

Q. And Dr. Becker gave some evidence when he was on the stand that in a standard





1  
2 autopsy there are not signs of digoxin toxicity that  
3 can be revealed. Is that something you would agree  
4 with?

5 A. Yes.

6 THE COMMISSIONER: Are revealed, I  
7 guess.

8 MS. CHOWN: Q. Quite correct. It  
9 is not possible to make pathological findings relating  
10 to digoxin toxicity in a standard autopsy?

11 A. Yes, that is correct.

12 Q. Yesterday Mr. Percival, Volume  
13 41, page 8294, was also asking you some questions  
14 about the preparation of Exhibit 198 and, starting  
15 on page 8293 he was asking you with respect to the  
16 conclusions of digoxin overdose that you had drawn  
17 as the cause of death, the question at line 22:

18 "I'm trying to find out the basis on  
19 which you formed those conclusions,  
20 that is all, Doctor.

21 "A. Yes.

22 "Q. You had clinical evidence,  
23 pathological evidence, digoxin test  
24 results?

25 "A. Yes."

I wanted to take you back to your







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2

answer there in response to Mr. Percival's question  
about the basis on which you formed those conclusions.

3

4

Am I correct in assuming that you did  
have the digoxin test results with respect to the  
cases of Pacsai, Miller and Estrella?

5

6

A. That is correct.

7

8

9

10

Q. I think you just indicated  
to Mr. Scott that you had the digoxin readings for  
Cook. Is that in fact correct at the time you were  
preparing Exhibit 198?

11

12

A. We did not have the test  
results then.

13

14

Q. That was my understanding.  
I wanted to clear that up.

15

16

Did you in fact have any pathological  
evidence of digoxin overdose at the time you were  
preparing Exhibit 198?

17

A. No --

18

19

THE COMMISSIONER: You had better  
answer no to that one because you have just told us  
that there are no pathological signs.

20

21

22

23

24

25

THE WITNESS: No. The reason I  
hesitated was actually it really should be Dr. Cutz  
that answers that sort of question because I am sure  
that he is the one who did the last two lines of this,





1  
2 because those were his cases. So I should not go  
3 into great detail of answering things about Cook.

4 Q. I am simply trying to clear  
5 up your answer to Mr. Percival and suggest to you  
6 that in forming your conclusions about four possible  
7 cases of digoxin overdose that you listed on Exhibit  
8 198, in fact is it fair to say that the basis for that  
9 conclusion was the digoxin test results with respect  
10 to the three patients I have mentioned?

11 A. Could you say that again  
12 please.

13 Q. All right.

14 MR. YOUNG: I'm sorry, Mr. Commissioner,  
15 before Miss Chown goes into that, I think it might  
16 be fair to the witness if she read the next question  
17 which deals with the atmosphere, and I believe the  
18 Doctor suggested that that, too, was a consideration  
19 in the diagnosis that he eventually came to.  
20  
21  
22  
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Q. Yes, I'm going to put that to him. Doctor, what I am simply trying to clear up is; you have told us that there is no way to obtain a pathological finding related to digoxin toxicity.

A. Yes.

Q. You agree with Dr. Becker on that?

A. Yes.

Q. It appeared in your answer to Mr. Percival's questions.

THE COMMISSIONER: There is of course a way of finding out. The Doctor has said there was no way of finding<sup>out</sup> pathologically, but surely the digoxin level tests can be taken, that is a fair --

MS. CHOWN: I quite agree.

THE COMMISSIONER: That is a form of pathology, is it not, to have a test toxicity taken?

THE WITNESS: I think that falls more in toxicology rather than pathology.

THE COMMISSIONER: Then you are right and I am wrong.

MS. CHOWN: I was simply separating them because Mr. Percival had put them as two





F2

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categories, and I obviously in trying to clear this  
up am perhaps muddying the waters.

3

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Q. Doctor, you have said there  
cannot be pathological evidence apart from digoxin  
readings that you characterized as toxicological  
to show digoxin toxicity.

8

9

10

11

And can you assist me that in  
coming to the conclusion that there was a digoxin  
overdose, as indicated on Exhibit 198 with respect  
to four patients, what was the basis of your conclu-  
sion with respect to those cases?

12

13

14

15

A. Well, certainly for the three  
that we have digoxin readings it was the digoxin  
level that we perceived was the basis of putting  
digoxin overdose beside those.

16

17

18

19

20

Q. You have mentioned earlier  
the effect of hindsight once you have had your  
discussion with Dr. Tepperman. Mr. Percival went  
on at page 8294, line 11 to indicate to you that  
at that time of preparing Exhibit 198, you were  
aware of a:

21

22

23

24

25

"...milieu or atmosphere then prevail-  
ing in the Hospital of something  
sinister going on so far as digoxin  
overdosage was concerned?"







F3

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And you agreed with him at that point that that  
also had some influence on your coming to that  
conclusion?

5

A. Yes.

6

7

MS. CHOWN: Thank you, those are  
my questions.

8

9

THE COMMISSIONER: All right, thank you.  
Well, we will take 20 minutes.

10

---Short recess.

10

---Upon resuming.

11

THE COMMISSIONER: Yes, Mr. Lamek.

12

MR. LAMEK: Thank you, sir.

13

RE-DIRECT EXAMINATION BY MR. LAMEK:

14

15

Q. Dr. Mancer, this strange  
process you have been subjected to is coming to an  
end.

16

17

18

19

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21

I was interested in what you told  
Mr. Scott about the protocol which we marked as an  
exhibit a couple of days ago, the protocol,  
September 7th, 1982. Can you tell me please how  
long, on the average, if there be an average, does  
an autopsy of a small child take?

22

A. It varies with the complexity  
of the case.

23

24

25

Q. Of course.





1  
2  
3 A. And the experience of the  
4 prosector. An inexperienced prosector would take a  
5 long time with even quite a simple case, than an  
6 experienced one. I have taken as much as nine hours  
on autopsy, roughly.

7 Q. And as little as?

8 A. And as little as half an hour.

9 Q. Half an hour.

10 A. To do the gross autopsy, not  
the great autopsy.

11 Q. Now I am interested <sup>that</sup> ~~in~~ the  
12 protocol that you designed and then revised doesn't  
13 expressly state that the body is not to be removed  
14 between the two periods of sampling. I can under-  
15 stand it is implicit ~~in~~ that the cavity is not to  
16 be closed, because otherwise you would have to reopen  
17 it in order to perform the second sampling, would  
you not?

18 A. Yes.

19 Q. But is it implicit in this  
20 that the body is not to be moved from the table  
21 between the two samplings even though the autopsy  
22 be completed within an hour?

23 A. Well, yes, at the present time  
24 the body would stay in the autopsy room for three  
25





1

2

hours.

3

Q. On the table?

4

A. On the table.

5

6

Q. That was your intention when  
you designed the protocol?

7

A. Yes.

8

Q. It doesn't so state ~~that~~  
though?

9

10

A. No, but that would be our  
intention.

11

12

Q. I take it you cannot tell us  
that in every case where this protocol was followed  
that intention was in fact implemented?

13

14

A. No, I cannot.

15

16

THE COMMISSIONER: I take it you  
are just as interested as Mr. Scott in picking up  
those problems that might arise?

17

18

19

20

21

THE WITNESS: Well, actually, we  
did consider the possibility of sewing up the body  
and bringing it down to the morgue and doing every-  
thing the same, but I decided that would be too  
cumbersome a procedure.

22

23

24

25

MR. LAMEK: Q. You did contemplate  
duplicating as close as you could the process of  
the Estrella sample?







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A. Yes.

3

Q. That is to say closing the

4

incision, removing the body, taking it to the morgue,

5

going down, reopening the incision and taking the

6

samples in that new location?

7

A. Yes.

8

Q. And I take it had you considered

9

that the degree of interference that might occur as

10

a result of the moving and the closing and the

11

reopening would have been significant to the results,

12

then you would have done that no matter how cumber-

13

some it was.

14

A. We probably would, yes.

15

Q. And therefore the fact that

16

you decided not to go to this cumbersome length

17

rather suggests, does it not, Dr. Mancer, that you

18

did not consider those elements in the Estrella

19

story to be of particular significance?

20

A. At that time I didn't think

21

it was important enough to do. I didn't consider it

22

at that time.

23

Q. When you say at that time,

24

I understand, Dr. Mancer, that over the course of

25

the last two and a half years you, and I guess

everybody who has ever been associated with this case





1  
2 knows a good deal more about digoxin than was known  
3 then. But I take it that your knowledge and aware-  
4 ness of questions of contamination, qua contamination  
5 is the same now as it was then?

6 A. Well, contamination, I think  
7 all of these sorts didn't really pass through my  
8 mind at that time designing the protocol, all of  
9 the possible sources of contamination. I think some  
10 of them. But the sloshing around of the fluid I  
11 really didn't, I don't think, reach that as a  
12 possibility.

13 Q. Doctor, to be blunt about it,  
14 you don't rate it as a very great possibility even  
15 now, do you?

16 A. It is a possibility.

17 Q. I think that answers the  
18 question.

19 MR. SCOTT: Do I take it that that  
20 is a negative answer? We might as well have it  
21 from the Doctor, if he says it is no significant  
22 source of contamination we will just let it go.

23 THE WITNESS: I don't think we will  
24 go that far to say it is of no significance, but it  
25 is possible, it is a possible.

MR. LAMEK: Q. It is a possible.





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A. Yes.

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THE COMMISSIONER: Which one are we talking about? A possible, that is the sloshing around?

5

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THE WITNESS: Yes, relating to the moving of the body from the autopsy table onto the stretcher, or the carrying case to the morgue, and then the same process back that one wouldn't bring it back, you would leave it in the morgue.

10

MR. LAMEK: Q. Sure.

11

12

A. Yes. All this, the sloshing around would relate to that.

13

14

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Q. And to the extent to which it is a possible source of contamination I suppose is a function of a whole number of things, is it not; the quantity of fluid which is in the cavity in the first place. We are talking <sup>gaily</sup> ~~daily~~ about sloshing around, but that rather suggests to me buckets full of water staying around in that cavity. We're not talking about that, are we?

20

A. No.

21

22

23

Q. No, of course we are not. We are talking about relatively small quantities of fluid there, are we not?

24

25

A. Yes.





1  
2  
3 Q. Sloshing is a lovely graphic  
4 word, but can we agree it is not entirely apt to  
5 describe the concern we might have as a possible  
6 contamination?

7 A. Yes.

8 Q. Now with respect to this  
9 leg vein sample that we have heard about; you have  
10 described for us in your examination in chief and  
11 again with Mr. Scott this morning, the procedure that  
12 you consider would have been followed for milking  
13 this leg vein. We have heard about the squeezing of  
14 the leg and the holding of the receptacle, the raising  
15 of the foot and all those things. Dr. Taylor was  
16 I believe performing his first autopsy at the  
17 Hospital for Sick Children in the Estrella case?

18 A. Yes.

19 Q. But I do not take it from that  
20 that he was ~~in an~~ <sup>in</sup> experienced resident pathologist,  
21 was he?

22 A. No.

23 Q. Indeed, can you recall for  
24 us what measure of experience he had as of January  
25 1981?

A. Well, he would have had at  
least three and a half years of pathology, because







1  
2 he was doing his, he took his examinations the fall,  
3 November, after - in November of 1981. He was  
4 appointed to the staff of the Vancouver General as  
5 of July 1st, 1981, and he would have to be finished,  
6 and he would have to have four years to be finished,  
7 so he had at least three and a half years.

8 Q. He was in the final stages of  
9 his residence, was he?

10 A. Yes.

11 Q. He was no <sup>neophyte</sup> neovite in this  
12 pathology game?

13 A. That is right.

14 Q. And Dr. Gillan was with him  
15 I understand. Can you tell us something about his  
16 experience?

17 A. Well, Dr. Gillan was more  
18 experienced. He had four years of pathology training  
19 in Ireland before he came to our department, and  
20 he had spent, at that point, I believe two and a half  
21 years in our department, and he had also done some  
22 research in pathology, and I am not sure whether  
23 that counted in his four years in Ireland or not,  
24 I believe it did count.

25 Q. But again a physician with <sup>a</sup> not  
~~an~~ inconsiderable measure of experience in pathology?





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A. That is correct.

3

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Q. And the two of them went down  
to take this sample?

5

A. Yes.

6

7

Q. Dr. Taylor had in ~~effect~~ <sup>fact</sup>  
performed the autopsy on Estrella?

8

A. That's right.

9

10

Q. And it was he who has recorded  
the presence of interstitial edema that is recorded in  
the autopsy report, Mr. Scott directed you to it.

11

A. Yes.

12

13

Q. And he if anybody would have  
observed that?

14

15

A. Observed it during the course  
of ---

16

17

Q. Observed it during the course  
of the autopsy?

18

19

20

21

Q. Is it reasonable to think that  
he may have been aware of the possibility of  
contamination by that interstitial edema fluid in  
the course of milking the vein?

22

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A. Well, I am not sure that that  
would have occurred to him. After all this is  
probably the first time he used that technique. I





1  
2 shouldn't say it was probably the first time, it  
3 was not likely he had used that technique to get  
4 blood many times before, and of course he didn't  
5 have very long to think about it either.

6 Q. Well, it may be, Doctor, that  
7 by good luck, or by very good judgment, he devised  
8 a method of obtaining the blood from that vein which  
9 helped to circumvent some of the concerns that you  
10 have expressed. Are you aware of the evidence that  
11 Dr. Taylor gave at the Preliminary Inquiry in the  
12 Crown against Nelles?

13 A. Some of it was read?

14 Q. Yes, it was.

15 A. I don't believe I have read  
16 the transcript.

17 Q. I'm going to read to you part  
18 of it, and it is found, Mr. Commissioner, in Volume  
19 17 of the transcript of the Preliminary Inquiry at  
20 pages 111 to 112. He was asked at line 15 on page  
21 111:

22 "Q. Where did you take this blood  
23 sample, from what part of the baby's  
24 body..."

25 Speaking of Estrella:

"A. There were two samples, one





1

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"sample was obtained from blood milked  
from leg veins.

3

4

Q. Where?

5

6

A. The leg veins, and the second  
sample was obtained from blood and  
fluid in the pelvic cavity of the  
body.

7

8

9

Q. In the pelvic cavity, could  
you show us where that would be?

10

11

A. Up and down here.

12

13

Q. You are indicating in the  
stomach?

14

15

A. Yes.

16

17

Q. All right, did you take  
both those samples?

18

19

A. Yes.

20

21

Q. All right, and how did you  
take them?

22

23

A. I took them with a syringe."

24

25

Now, does that suggest, Doctor, that  
he was not using the receptacle gathering technique  
that you have described?

A. Yes.

Q. Now, he will be here and he  
can tell us precisely what he did. But if in fact







1  
2 what Dr. Taylor did was insert a syringe into the -  
3 cut ~~in the~~ vein and then squeezed down to gather his  
4 material, he would avoid some of the contamination  
5 that you have been concerned about, would he not?

6 A. Yes.

7 Q. He would avoid the squeezing  
8 down of the surrounding edema fluid?

9 A. Yes.

10 Q. He would avoid any contamina-  
11 tion resulting from the material exiting from the  
12 vein and passing over, no matter how small an area,  
13 of the body cavity to reach the receptacle, would  
he not?

14 A. Yes.

15 Q. And therefore, as I say, we  
16 may have to ask him whether this was good luck or  
17 good management. But indeed if he did use that  
18 technique it is something other than the one that  
you had contemplated, was it not?

19 A. Yes.

20 Q. And indeed may I suggest,  
21 Doctor, a preferable technique if you have to use  
22 the device of milking the vein?

23 A. Yes.

24 Q. Let's go back ---  
25





1  
2  
3 MR. SCOTT: Mr. Commissioner, can I  
4 ask my friend a question? The part of Dr. Taylor's  
5 evidence he has read is quite correct but it may be  
6 useful to clear up while we have this witness in  
7 the witness box, whether the answer of doing with  
8 a syringe means to Dr. Mancer a syringe with or  
9 without a needle.

10 Now, there will be some evidence from  
11 Dr. Taylor on how he took it, and I don't want to  
12 get into that. I don't know whether it makes any  
13 difference, but rather than have Dr. Mancer back to  
14 deal with those answers it may be Mr. Lamek might  
15 consider pursuing and that. It may make no difference.

16 MR. LAMEK: I have no concern about  
17 pursuing that at all.

18 Q. What I put to you, Doctor ---

19 THE COMMISSIONER: Before we go into  
20 that, how does one operate a syringe, is it like  
21 one of those things you baste chickens with?

22 THE WITNESS: I don't know about  
23 those things.

24 MR. SCOTT: I am not sure I can  
25 take this four days a week.

THE COMMISSIONER: Can a syringe  
operate without a needle?





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THE WITNESS: Yes, it can.

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MR. LAMEK: Q. Can you tell us,

Doctor, a child the age of Estrella and for the life of me I don't now remember how old she was; what would be the diameter of the iliac vein at the point where it enters the body cavity?

THE COMMISSIONER: Four months.

THE WITNESS: It would be about 2 to 3 millimetres.

MR. LAMEK: Q. That is really very small?

A. Yes.

Q. Well, we will have to ask Dr. Taylor whether he had a needle on his syringe and exactly what he did. If he did what I have suggested to you, we are agreed that would avoid some of the areas of concern that you have expressed about contamination?

A. Yes.

MR. SCOTT: The question I was asking my friend to ask, and he doesn't have to ask it, would the answers be any different if the syringe was used without a needle. Now if he says that may be improbable we will have to wait and ask Dr. Taylor.

MR. LAMEK: Q. Let me ask the





1  
2 first question then, Dr. Mancer. You have described  
3 the internal diameter of the blood vessel that we  
4 are talking about. Could one insert into that  
5 a syringe without a needle?

6 A. Yes.

7 Q. And if one were to do that  
8 would it still alleviate some of the concerns that  
9 you have expressed in the course of your evidence  
10 about contamination?

11 A. Well, it would not be easy to  
12 insert it without a needle.

13 Q. That is what I would have  
14 thought.

15 A. And one would have to somehow  
16 grasp the cut end of the vein and force it in. Now,  
17 with a needle one would have to somehow grasp the  
18 end of the vein also, and presumably in -- in order  
19 to get a proper sample with the needle, because the  
20 blood would tend to flow out one would have to tie  
21 the end of the vein.

22 Q. Doctor, I think we will have  
23 to wait and see exactly what Dr. Taylor did. May we  
24 at least go this far, that if he were able to devise  
25 a technique with that syringe, which enabled him to  
collect the sample before it exited from the vein,







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that would allay some of the concerns that you have  
been talking about, would it not?

3

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A. Yes.

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Q. Yes. Indeed, to use Mr.

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Scott's example, it is a bit like having the contaminated  
neck of the bottle so using a straw to drink the  
milk, isn't it?

4

5

A. Not quite.

6

Q. Well, you avoid the  
contamination of the mouth.

7

8

A. The straw is passing over  
the mouth. I mean, in this particular case the  
syringe is passing over the mouth, whereas, the  
straw would tend to go just right into the bottle.  
So it isn't quite the analogy.

9

10

11

12

Q. All right.

13

THE COMMISSIONER: I think what  
we will do now is we will sit from Sunday to Wednesday.  
It would be better to avoid Thursday.

14

15

16

MR. LAMEK: Thursday is clearly  
a bad day.

17

18

Q. Dr. Mancer, just let's

19

go back for a moment though to your knowledge of  
contamination. You may have focused more upon

20

possible ~~routes~~ <sup>routes</sup> of contamination in the course of

21

the last two and-a-half years but your knowledge of

22

sources of contamination is no greater now than it

23

was then, I take it? You knew then that edema fluid  
could contaminate a blood sample; indeed, you were

24

25





G2

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told that in the report itself, were you not?

3

A. Yes.

4

Q. Yes. You knew then that

5

body cavity fluid could contaminate the kind of

6

sample that we've been talking about, this venous

7

sample? You knew all of that then?

8

A. Yes.

10

Q. You knew, did you not,

11

at the first week of March 1981 that the only sample

12

upon which you were then focusing, the 72 nanogram

13

sample, was contaminated to some extent by edema

14

fluid and ascitic fluid?

15

A. Yes.

16

Q. That was expressly

17

stated not as a remote possibility but as a fact

18

by Dr. Taylor, was it not?

19

A. Yes.

20

Q. But on March 20th when

21

you decided to report the Estrella death to the

22

Coroner you had no misgivings about that decision

23

based upon the known fact of some contamination, did

24

you?

25

A. No.

Q. No. The contamination,

even though known to you, of the only sample upon





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which you were focusing did not affect your judgment that this was a death which in the light of the Pacsai case had to be reported because there were recorded digoxin levels which had to be investigated?

A. Yes.

Q. Yes. I thought I had this clear in your evidence in chief, Dr. Mancer, but I ~~am~~ <sup>became</sup> a little confused in the course of the cross-examination. Can you help me? What is your best information as to when Dr. Taylor learned of the Estrella levels?

A. Approximately ten days after the autopsy.

THE COMMISSIONER: Ten days after what?

THE WITNESS: The autopsy.

THE COMMISSIONER: All right.

MR. LAMEK: Q. Which was the 11th of January?

A. Yes.

Q. All right. Do you recall preparing yourself to give evidence at the preliminary inquiry in the Nelles prosecution?

A. I did certainly do that.

Q. Yes. And in the course







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of preparing yourself to give evidence there, did you make any enquiries then as to when the Estrella level information had come to Taylor's attention?

A. I think that that information would have been obtained by me not immediately before the appearance at the inquiry but much earlier. Like, I had asked Dr. Taylor to write down what he could recall about the Estrella autopsy and we talked about it in the week following the 20th, because I knew there was going to be something develop out of this, some court proceeding.

Q. Sure.

A. And I thought it was important that we have lots of reliable information.

Q. Doctor, do you recall whether in either noting the information you received at that time or in preparing yourself to give evidence at the preliminary inquiry you made any notes as to your recollection or information and, in particular, whether you made notes on the copy of the Estrella autopsy report?

A. Yes, I did.

Q. And would it assist your recollection as to what your then information was if you were to look at those notes?





Mancer  
re.dr. (Lamek)

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A. The information I had  
just before the Estrella -- I mean before the  
preliminary.

Q. Yes.

A. Yes.

Q. Let me show you a copy  
of the Estrella final autopsy. Can you tell me first  
whether the pencil handwriting on the first page is  
yours?

A. Yes.

Q. Now, there is a note on  
the left-hand side of that document which I believe  
suggests that the Estrella digoxin levels were  
reported to Dr. Taylor on January 17th.

A. Yes.

Q. And does that assist your  
recollection as to when those results came to his  
attention?

A. Yes.

Q. All right. Not ten days  
but perhaps six or seven days --

A. Yes.

Q. -- after the autopsy.

The note continues, does it not,  
that he held the digoxin information, that is to say,





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he kept it, held on to it trying to see Dr. Freedom?

3

A. That's correct.

4

Q. And he happened to see

5

Dr. Freedom about a week later?

6

A. Yes.

7

Q. And do I take it then it

8

was your information that the digoxin level information

9

came to Dr. Taylor on or about the 17th of January

10

and from him to Dr. Freedom on or about the 24th of  
January?

11

A. That would be more

12

reliable in that it was written down at the time.

13

Q. Yes. Thank you.

14

Now, just one other matter,

15

Dr. Mancer, if I may.

16

Miss Symes yesterday talked with

17

you about your perception on March 20th that some

18

pages of the Estrella chart were missing and I think

19

we were able to satisfy ourselves that they were

20

missing then, they are certainly not missing now and

21

they were probably not missing then; is that fair?

22

A. Yes.

23

Q. So, I am not interested

24

in whether the pages were missing but I am interested

25

in your perception on March 20th that they were missing,





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because you have told us that you so reported to

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Dr. Tepperman.

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A. Yes.

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Q. And I take it therefore

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that the missing pages, as you then believed them to  
be, were a matter of some significance to you?

7

A. Yes. I thought that

8

Dr. Tepperman's attention should be drawn to the

9

possibility of anything missing.

10

Q. And you told Mr. Percival

11

that those missing pages, as you believed them to be,  
gave you some concern. I think those were your  
words to Mr. Percival?

12

13

A. Yes.

14

Q. Now, just what was the

15

concern that you had when you believed that pages

16

were missing covering the administration of drugs

17

for the last three days of that baby's life?

18

A. Well, somebody might

19

have altered the chart.

20

Q. That there had been

21

perhaps a deliberate removal of the pages?

22

A. Possibly.

23

Q. And was that a matter of

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some concern to you because it raised the possibility

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that someone was anxious to conceal something that  
might have appeared from those pages?

A. Yes.

Q. Conceal a misadministration  
of the digoxin, that was the fact you were focusing  
on?

A. I'm not sure.

Q. I don't mean intentional;  
I don't say intentional, but a misadministration.

MR. SCOTT: Mr. Commissioner,  
with the greatest of respect, my friend has established  
quite properly that the doctor was suspicious about  
these missing pages. Is it of any help to the  
Commission, having established that he was suspicious  
and reported to the Coroner, to elaborate his  
suspicions if they are simply the function of his  
mind?

MR. LAMEK: Well, Mr. Commissioner,  
in the light of the evidence Dr. Mancer has given  
that it was not until he spoke to Dr. Tepperman that  
his suspicions were aroused, it may be of interest  
to know what the basis for the concern was --

THE COMMISSIONER: Yes.

MR. LAMEK: -- prior to his call  
to Dr. Tepperman.





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THE COMMISSIONER: Well, I think  
you can carry on.

MR. LAMEK: It won't take more  
than a half a minute, sir, I promise you.

Q. Was your concern the  
possibility that someone was trying to conceal a  
misadministration, an overdose, not necessarily  
intentional, of a drug by the removal of pages?

A. I think that would  
probably be my concern. I can't remember. All this  
happened very quickly.

Q. Yes, I know.

Q. I am not sure whether  
my thought processes had gone that far or not at that  
point.

Q. Can you tell us whether  
your thought processes had gone so far in trying  
quickly to assess the significance, if any, of those  
missing pages as to consider the possibility that  
someone was removing evidence of an intentional wrong?

A. Could you state that again,  
please.

Q. Yes. Did you consider  
the possibility that it was an intentional mis-  
administration that was being concealed by the





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removal of pages?

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A. I don't think that my

4

thoughts really went that far.

5

Q. All right.

6

A. Because it wasn't until --

7

You see, I noticed that -- I was going through the  
chart prior to my conversation with Dr. Tepperman

8

while I was in Dr. Ellis' office --

9

Q. Yes.

10

A. -- and that was over a

11

period of, maximum, twenty minutes. During that

12

time, not only was I going through the chart, I was  
also talking to Dr. Ellis about his results. I had

13

just heard twenty minutes before from Dr. Cutz about

14

this high level. There wasn't much time --

15

Q. I know things happened

16

very fast.

17

A. -- and during this

18

period I was going through the chart and seeing if  
there was anything unusual in there, and those were  
points that I had focused on at the time of Dr.

19

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Tepperman's call and I thought I should draw them  
to his attention.

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22

Q. Thank you.

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Yesterday in the course of

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cross-examination Mr. Olah - and this is found at  
page 8361, Mr. Commissioner, of yesterday's tran-  
script - talking to you about the chart of deaths that  
you prepared with Dr. Cutz on the 24th/25th of March,  
speaking of the Hines baby and your notation there  
that the cause of death was undetermined asked you  
this question - line 10, Mr. Commissioner:

"Q. In any event, Doctor, the  
point I did want to make is this.  
Certainly when you prepared this  
document, and I think you have  
advised us of this, you felt that  
digoxin could not be ruled out as  
the cause of death with respect to  
Baby Hines."

And your answer was:

"A. Yes, in the setting that  
we were in on March 24th or 25th."

I just want to be clear. You  
are contrasting that setting I take it with the  
preceding period rather than with the subsequent  
period?

A. Yes.

Q. Okay. You are not  
suggesting that the setting has now changed so that







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you would now be able to rule out digoxin?

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A. I am not suggesting that.

4

Q. No. And your reasons

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for calling the Hines death undetermined as at

6

March 24 or 25, 1981 are still valid in your own

7

mind today, are they?

8

A. Yes.

9

MR. LAMEK: Dr. Mancer, thank you

10

very much.

11

THE COMMISSIONER: Thank you,

12

Doctor. Thank you very much indeed and that is the

13

end for you, for us.

14

THE WITNESS: To my great relief.

15

--- witness withdraws.

16

THE COMMISSIONER: Yes, Miss Cronk.

17

MS. CRONK: Our next witness,

18

Mr. Commissioner, is Dr. Ernest Cutz.

19

ERNEST CUTZ, Sworn

20

THE COMMISSIONER: The spelling

21

of your name, Dr. Cutz.

22

THE WITNESS: C-u-t-z.

23

THE COMMISSIONER: Thank you.

24

DIRECT EXAMINATION BY MS. CRONK:

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Q. Dr. Cutz, as I understand

it you are a Canadian citizen and were born in





1  
G13 2 Czechoslovakia in 1942?

3 A. That is correct.

4 Q. Right. You received your  
5 Medical Degree in 1966 from Charles University  
6 Medical School in Prague, Czechoslovakia.

7 A. That is correct, yes.

8 Q. And from 1966 to 1967  
9 you did Post-Graduate training at the same university  
10 and obtained what I understand to be the equivalent  
11 of a Ph.D in Histology.

12 A. No. I had not completed  
13 it.

14 Q. All right. You were  
15 working on it at that time?

16 A. Yes, that's right.

17 Q. Perhaps to assist you,  
18 Doctor, a copy of your curriculum vitae has been  
19 provided to me. I would ask you to look at it if  
20 you would and tell me if it is yours.

21 A. Yes, it is.

22 THE COMMISSIONER: Exhibit 203.

23 --- EXHIBIT NO. 203: Curriculum vitae, Dr. Ernest  
24 Cutz.

25 MS. CRONK: Q. Doctor, throughout  
the copy of your curriculum vitae there is a number





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of references to histology. We have had it before but the term that we have become most used to in these proceedings is pathology. Can you draw for me if there is one what the distinction is between the two?

A. Well, histology is the study of tissues under the microscope and histology as such, it may refer to the study of normal tissues as well as the study of normal or diseased tissues; in that case it is called histopathology.

Q. I see.

A. But histology basically is the general discipline of the microscope anatomy of tissues.

Q. And as I understand it then from what you told me a few moments ago, for the year 1966 to 1967 you spent some time at the Charles University Medical School working in that field?

A. That is correct, yes.

Q. And the following year, Doctor, noting from your curriculum vitae, from 1967 to 1968 you did a Residency in Pathology in Toulouse, France; is that correct?

A. That is correct, yes.





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Q. And in September of 1968  
you became a Research Fellow at the Department of  
Pathology and at the Research Institute at The  
Hospital for Sick Children; is that correct?

A. That is correct.

Q. Right. And you  
continued in that position until June of the follow-  
ing year, 1969?

A. That is correct.

Q. Right.

And if I understand it correctly  
from July of 1969 until June of 1970 you did a  
Residency in Pathology at the Department of Pathology  
at the University of Toronto and, in addition, at  
the Banting Institute in Toronto and, in addition,  
at the Toronto General Hospital?

A. No, that is all the same  
place.

Q. All right. Then I have  
read it wrong. I thought you had a very busy year  
and that is why I put it to you that way.

A. Well, you know, at the  
time these services were in different buildings.

Q. I see.

A. But autopsy service would







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be in the Banting Institute.

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Q. I see.

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A. So, part of my training

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would be there in the Surgical Laboratory would be  
in the General Hospital, the Toronto General.

6

Q. Thank you, Doctor.

7

A. So that we rotate.

8

Q. I think I understand

9

it better now.

10

The following year then, Doctor,

11

from July of 1970 until June of 1971 you were the

12

Senior Resident in Pathology at the Wellesley and

13

Princess Margaret Hospitals here in Toronto.

14

A. That is correct, yes.

15

Q. And in 1971 you were

16

appointed as Senior Staff Pathologist in the Department

17

of Pathology, again at The Hospital for Sick

18

Children.

A. That is correct, yes.

19

Q. And you have continued

20

there in that position to date, as I understand it.

21

A. That is correct, yes.

22

Q. And as well, Doctor, over

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the years as I understand it you have devoted a portion of  
your time to teaching efforts.

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A. Yes.

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Q. For example, from 1971

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to 1973 you were a Research Associate at the Department of Pathology at the University of Toronto.

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A. That is correct, yes.

6

Q. And then in 1976 you

7

became an Assistant Professor.

8

A. That is correct.

9

Q. And in 1980 an Associate

10

Professor.

11

A. That is correct.

12

Q. Is that an appointment

13

you continue to hold today, Doctor?

14

A. Yes, that is correct.

15

Q. Thank you.

16

Doctor, there are as well I take

17

it a number of professional organizations and groups

18

to which you belong and they are detailed I gather in your curriculum vitae.

19

A. Yes, that is correct.

20

Q. Similarly, there are a

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number of articles, abstracts, book chapters, things of that nature in the fields both of Histology and

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Pathology which you have either authored or in whose

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authorship you have participated, and they are set

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out in your curriculum vitae as well.

A. Yes, that is correct.

Q. Thank you, Doctor.

Doctor, specifically, there are two areas which I would like to discuss with you today. The first has to do with autopsies conducted as I understand it by you or under your supervision on a number of children at the Hospital and, secondly, the events of March 24th and March 25th and the preparation of various charts by Dr. Mancer and yourself about which perhaps you have heard a little bit this morning.

May I ask you, Doctor, were you present here this morning for part of the evidence of Dr. Mancer?

A. Yes. I came about 10:15, 10:30, something like that.

Q. Thank you, Doctor.

If we could deal first with the case of Amber Dawson. That child died at The Hospital for Sick Children on July 28, 1980. As I understand it you conducted the post mortem on her body.

A. Yes, I did. I would like to look at my notes.

Q. Absolutely, please feel





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free.

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Perhaps, Mr. Registrar, if you could get as well Exhibit 124, which is the bound volume of final autopsy reports that has been marked.

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8

I don't think you will need Amber Dawson's medical record, Doctor, but if it would be useful to you, please don't hesitate to ask for it.

9

10

11

Doctor, I had asked you whether or not you performed the autopsy of Amber Dawson and I believe your answer was, yes.

12

A. Yes, I did.

13

14

15

Q. Now, our understanding, Doctor, is that the death of Amber Dawson was reported to the Coroner and that the autopsy was conducted under a Coroner's Warrant.

16

Do I have that correctly?

17

A. That is correct.

18

19

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Q. So, in that regard, I take it that in the usual fashion a Resident Pathologist did not actually conduct the autopsy under your supervision but rather you yourself did so?

21

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A. No. I did the autopsy personally.

23

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Q. Thank you.







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Doctor, prior to conducting the  
gross autopsy --

A. Yes.

Q. -- starting the autopsy  
itself, did you have an opportunity to review the  
medical record for Amber Dawson?

A. No. I think the first  
consideration in such a case is to perhaps discuss  
the case with the Coroner or if he is not available  
to review his Warrant which would indicate information  
in terms of why an official autopsy is ordered or  
what particular things should be looked for.

Q. Did you in this case,  
Doctor, discuss the case of Amber Dawson with the  
Coroner before conducting the autopsy?

A. Yes, I believe I spoke  
with Dr. Bunt.

Q. And did Dr. Bunt at that  
time draw to your attention any particular facts from  
the clinical history or the circumstances of death  
of the child to which he wished you to have attention?





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A. Well, he mentions things

which are in the child, in terms of the events and the condition of the child, indicating that this child had previous surgery, and the reason why the child was admitted to the Hospital, and a note about the final event. His questions, if I may look at the Warrant -- I have so many papers here --

Q. If there is something particularly that you would like to refer to that was set out in the Warrant, Doctor, please take whatever time you need to find it.

A. I have the Warrant here.

Q. All right.

A. It indicates, with a query, "lung infection? failure" so I think that Dr. Bunt at this stage was thinking of some medical explanation for the demise of the child.

Q. And that was drawn to your attention before conducting the gross autopsy both by virtue of what was disclosed in the Warrant, that Dr. Brant had found, and as well by virtue of your discussion with Dr. Bunt himself?

A. Yes.

Q. In addition to that, Doctor, having regard to the fact that the child died in the





1  
2 Hospital, I take it that the medical record was  
3 available to you for your review?

4 A. That is correct.

5 Q. Did you personally review  
6 the record before conducting the gross autopsy?

7 A. Yes, I did.

8 Q. Thank you, Doctor.

9 Doctor, to your immediate left  
10 there is a volume of materials which is Exhibit 124  
11 in these proceedings and I would ask you to turn to  
12 Tab 4 - I don't know whether your copy is tabbed -  
13 page 59.

14 At pages 59 through 67, Doctor,  
15 do we find there, first the final autopsy report  
16 which you prepared on Amber Dawson and, secondly,  
17 the report of post mortem examination which you  
18 prepared for the Coroner's Office?

19 A. Yes.

20 THE COMMISSIONER: I take it that  
21 is not in the medical record?

22 MS. CRONK: It may well be, Mr.  
23 Commissioner. I have just been working from the  
24 other exhibit.

25 THE COMMISSIONER: Well, it might  
not be, because --





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THE WITNESS: They should not be in the medical record because once it goes to the Coroner --

MS. CRONK: As it happens, sir, the medical record is Exhibit 59 and if you turn to page 59 as well we find there the report of post mortem examination.

THE COMMISSIONER: All right, thank you.

MS. CRONK: I do not think, sir, that the final autopsy report is contained in the medical record.

Q. I will come back to that in a moment, Doctor, but if I could direct your attention first to the gross autopsy, can you tell me, prior to conducting the gross autopsy, had you then in your mind, on the basis of your discussion with Dr. Bunt, the contents of the Coroner's Warrant or your review of the medical record, any possible cause of death for this child, leaving aside the issue of lung infection, which you indicated had been raised.

Was there anything else in your mind at that time?

A. No.







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Q. After the gross autopsy, Doctor, without more, and by that I mean without the results of microscopic examinations which I understand were conducted, were you able at that stage to formulate an opinion as to the probable cause of death of Amber Dawson?

A. Immediately after the autopsy I had several findings. Some were perhaps confirmatory in terms of what the clinical diagnosis was that the child had congenital heart disease of the type where you have holes between your chambers and she in fact underwent surgery for correction of these defects. The autopsy revealed that this was the case, the defects had been repaired.

The next finding, which was a bit surprising - I was not expecting it - was the finding of an area on the stomach which at the time of the gross autopsy appeared as if it may have been an abscess and knowing that this child, in addition to the congenital heart disease, also had paralysis of the diaphragm, or one part of the diaphragm did not function, and this developed as a complication following surgery, this would explain, first of all, a possibility of the lung





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collapse or the infection, because the diaphragm is not moving. The second, one of the known complications of the paralysis is development of an abscess.

Q. I see.

A. So this was my first impression that this lesion around the stomach and under the diaphragm could be a subphrenic abscess or an abscess under the diaphragm which had ruptured into the stomach. This would be - all the structures would be close together.

So that was my first impression. A ruptured abscess could be a cause of infection, generalized infection.

Q. Including infection of the lung?

A. It would be a sort of dissemination of the organisms into the whole body, possibly the lung as well.

Q. And all of those factors, Doctor, I take it were observed by you by virtue of your physical examination of the child on gross autopsy?

A. That is correct.

Q. Do I have it correctly,





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doctor, that, as part of the standard autopsy regimen, microscopic examinations were there conducted on various tissue samples from various organs in the body?

A. That is correct.

Q. And in this case as well were any further tests conducted?

A. Yes, because of the suspicion of infection in disseminated sections, I had taken samples for culture.

Q. And those samples were taken then to test the risk of infection by virtue of checking for bacteria?

A. No. It was to confirm the presence of infection.

Q. If we turn, if you would, doctor, to page 5 of your report of post mortem examination, I think it is numbered in this book page 66. Do you have that, doctor?

A. Yes, I do.

Q. Do we find there, doctor, under Section 7, your summary of abnormal findings which you observed in this child as a result of the tests you have just described?

THE COMMISSIONER: 63, I think





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it is.

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MS. CRONK: 66 in my book, sir.

4

63 in yours? Section 7, Summary of Abnormal Findings.

5

THE COMMISSIONER: I have 63.

6

MS. CRONK: You are looking,

7

of course, at the medical record and the witness and

8

I are looking at --

9

THE COMMISSIONER: Oh, yes.

10

For the benefit of anybody who

11

doesn't have that exhibit, it is Exhibit 59, page 63.

12

MS. CRONK: Thank you, sir.

13

Q. And under Section 7 of

14

that report, doctor, we see there the summary of your abnormal findings.

15

I take it those were the findings

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that presented themselves both as a result of the

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gross autopsy, the microscopic examination and the

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cultures which had been taken?

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A. That is correct.

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Q. Do I have this correctly

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then, doctor, looking at the contents of your

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summary, that, first, the diagnosis of congenital

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heart disease was confirmed?

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A. That is correct.

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Q. Secondly, as you earlier indicated, the surgical repair of those defects had been undertaken?

A. Yes.

Q. And the repair appeared to be successful, and that is what you reported?

A. That is correct.

Q. Thirdly, the heart defects had been closed and were intact, and that is what you reported?

A. That is correct.

Q. Fourthly, there was a deformity of the pulmonary valve?

A. Yes.

Q. If I am reading your summary section correctly, you regarded that as insignificant?

A. It was not a prime during life or during investigation of the child. This defect was, but it was not considered significant in terms of cause of death.

Q. It was not significant in terms of the cause of death?

A. That is right.

Q. Then, fifthly, there was





H9

1  
2 evidence as well of myocardial fibrosis in the  
3 child?

4 A. Yes.

5 Q. And you described that as  
6 being "old"?

7 A. That is correct.

8 Q. Anything so far in those  
9 findings, doctor, that could account, in your view,  
10 for the death of the child, in those findings?

11 A. Possibly the fibrosis  
12 in the heart. If it would involve, say, the conduction  
13 system or some structures nearby, then it possibly  
14 might have some effect, but we have not examined that  
15 possibility. It might have been a contributory  
16 factor but I did not think that was a primary -- that  
17 the extent was large enough to really consider it as  
18 a primary cause of death.

19 Q. Thank you.

20 Doctor, reading on in your  
21 summary, I take it there was a sixth finding, and  
22 that was of gastromalacia with perforations of the  
23 cardia, which you described as being recent and  
24 likely precipitated by vomiting experienced during  
25 life.

Doctor, correct me if I am wrong,





H10

1  
2 as I understand -- perhaps you could explain what  
3 you meant by that. What was the gastromalacia with  
4 perforations that you were referring to?

5 A. At the site where I  
6 thought there was an abscess, when it was examined  
7 microscopically, it did not show changes which one  
8 would expect to see with abscess. In particular,  
9 you would expect to see a lot of inflammatory cells.

10 Q. And did you?

11 A. No. There were no  
12 significant numbers of inflammatory cells. Instead,  
13 what the sections revealed was peculiar change in  
14 the wall of the stomach, which had a sort of glossy  
15 appearance under the microscope, which we call  
16 hyalohisation. This is recorded in autopsies as  
17 gastromalacia or dissolution of the wall of the  
18 stomach, which can occur in a particular point.

19 Q. In a layperson's termin-  
20 ology, doctor, it has been suggested to us in  
21 previous evidence that that might best be understood  
22 as perforations or holes in the stomach wall?

23 A. That is correct.

24 Q. And finally, doctor,  
25 as I understand it, the seventh finding was the  
presence of focal periventricular leukomalacia?





H11

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A. That is correct.

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Q. What were you talking

4

about with that finding?

5

A. This finding is based

6

on a neural pathology examination or examination of  
the brain, and this indicates again old lesions in

7

the specific areas of the brain which are associated

8

with episodes of hypoxia or lack of oxygen during

9

some period during the uterine life or around the

10

delivery time. This is found in babies who had

11

such an episode and/or some significant deprivation

12

of oxygen at some point.

13

Q. Doctor, on the basis of

14

all of those findings, there are some seven in total

15

that we have just gone through, was there anything

16

in those findings which, in your opinion at the

17

time, from an anatomical or pathological point of

view, could account for the child's death?

18

A. I could not actually

19

provide an accepted cause of death in the sense of

20

giving a usual type of cause of death which is clear

21

to anybody. In other words, some other considerations

22

would have to be taken of events which you cannot

see in a gross or microscopic examination.

23

Q. I take it then that,

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anatomically, based on the pathology findings and your examination of the anatomy, there was nothing you could pinpoint as being the cause of death?

A. That is right. Something in the sense of a massive hemorrhage or overwhelming infection which would be acceptable and accepted causes of death.

Q. They were absent --

A. Or a rupture of some viscus, or something like that.

Q. They were absent in this case?

A. Yes.

Q. Doctor, you told us that from the outset you were concerned about the possibility of lung infection. You told us there was that paralysis in the diaphragm that might have had some connection with infection.

Was there, at the completion of all the tests that were done, evidence of infection in the child sufficient, in your view, to account for her death?

A. We received cultures which the culture blood revealed an unusual organism, which I interpreted as being a contaminant, which





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happens sometimes, especially if there is a long post mortem interval. In this case, I believe the interval was 36 hours. This is not a kind of bacteria you would see with infection.

The other thing you have against an infection is the absence of inflammatory response in any of the tissues I looked at, which you would expect to see a lot of inflammatory cells.

Q. I take it then that --

A. So, the culture, we cultured something but I interpreted it as being a contaminant.

The second culture, which was from the area of the stomach perforation, showed a specific organism, referred to as E. coli, and this is an organism which is normally present in the bowel, so this would be expected, since there was some perforation, some leakage of the material from the gastrointestinal tract. So, this organism is different from the one which we had in the blood.

Q. I take it then, doctor, that, on the basis of those findings, the results from the cultures, infection was effectively ruled out by you as the cause of death?

A. That is correct.





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Q. Could the collapsed diaphragm, the paralysis of the diaphragm, of and in itself have accounted for the child's death?

A. I think maybe not directly but since the nerve, subphrenic nerve of the diaphragm, was severed, and that was probably the basis of the paralysis, and the other complication, I believe, which I am not expert on, but I believe, you can get a reflex cause of death which would be - and I heard that from my conversation with the cardiologist; that you can have such a mechanism of vagal reflex and, then, you do not see anything in the autopsy.

Q. Let me ask you this: At the time of signing out this final report, was it your view that the paralysis of the diaphragm, the collapse of the diaphragm, accounted for the child's death?

A. I thought that was a significant contribution except I could not put it down as the anatomical cause of death. So, I thought the death was due to natural causes. I had no doubt that it was due to natural causes, even though I could not pinpoint the precise anatomical cause of death.

Q. Is that why, doctor, in





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Section 8 of your report, under the "Cause of Death" section, you indicate that the "immediate anatomical cause of death was not determined." You then list two contributing factors: "Congenital heart disease and the right hemidiaphragm paralysis"?

A. That is correct.

Q. Dealing again specifically with the paralysis of the diaphragm, you mentioned severance of the nerve.

A. Yes.

Q. It is my understanding that that happened at the time of surgery with respect to the child.

A. That is correct.

Q. And that surgery, we know the child survived.

A. Yes.

Q. In your mind, doctor, was that complication of and in itself sufficient to account for death?

A. The severing of the nerve would not kill the patient but it would impair the function of the diaphragm, and the diaphragm is very important for breathing. If both leaflets of the diaphragm would be severed, the patient could not







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breathe unless you restore the diaphragm function.  
So, you can function with one diaphragm but there is  
risk of all kinds of complications arising. These  
are just a few I mentioned that I know of, but there  
are more than that.

Q. Do I take it, then, doctor,  
that, at the completion of the autopsy, in your view,  
the combination of the collapsed right diaphragm  
together with the congenital heart disease was  
sufficient to account for this child's death?

A. Yes.

Q. Doctor, at the time of  
the autopsy, we have heard in some cases that, at  
Coroner's autopsies, a drug screen is ordered.

A. Yes.

Q. Was there, in the case of  
Amber Dawson, a drug screen ordered by the Coroner?

A. No, it was not.

Q. Were the cultures which  
you have indicated were taken, were they ordered to  
be done by the Coroner, having regard to his concern  
about a lung infection, or were those cultures which  
you ordered to be taken in the normal course of the  
autopsy?

A. It is both. His Warrant





Cutz  
dr.ex. (Cronk)

H17

1  
2 indicates "as a possible cause, infection". And the  
3 second cultures are taken, in most cases, as a routine.  
4 That is a common finding in diseases of children,  
5 if you like; infection is one of the common causes  
6 of disease.

7 Q. Leaving aside the issue  
8 then, doctor, of a drug screen or special cultures,  
9 were you given any specific instructions as to tests  
10 which should be undertaken in this case by the Coroner?

11 A. No, I was not.

12 Q. Doctor, were you aware --  
13 on the basis of your review of the medical record and  
14 what you knew of this child's condition, did you  
15 have any reason at the time of signing out the  
16 autopsy report or the time of conducting the autopsy  
17 to consider whether or not digoxin had played any  
18 part in this child's death?  
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Q. At the time of signing out  
the autopsy?

A. Yes.

Q. And the actually carrying out  
of the autopsy did you then have any information  
in your possession which led you to consider  
digoxin as a possible contributing factor to this  
child's death?

A. No, I did not.

Q. Thank you very much,  
Doctor. Doctor, may we then turn to the case of  
Phillip Turner.

THE COMMISSIONER: I wonder would this  
be a good time.

MS. CRONK: Yes, thank you, Mr.  
Commissioner. I am sorry I lost track of the time.

THE COMMISSIONER: 2:30 then.

MS. CRONK: We will turn to Phillip  
Turner when we come back, Doctor.

THE COMMISSIONER: You might tell us  
which ones we are going to cover and that might  
help.

MS. CRONK: The remaining children  
that I understand were autopsied directly by  
Dr. Cutz are Phillips Turner, Kevin Pacsai, Allana





Cutz, dr.ex.  
(Cronk)

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Miller and Justin Cook. In respect of Kristin Inwood, Dr. Cutz completed the final sign-out on that autopsy. There are six in total.

THE COMMISSIONER: Yes, all right, thank you. Until 2:30 then.

---Luncheon adjournment.

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---Upon commencing at 2:30 p.m.

THE COMMISSIONER: Yes, Miss Cronk.

MS. CRONK: Thank you, sir.

Q. Doctor, just before we turn to the case of Phillip Turner, there are two matters in the case of Amber Dawson that I would like to clarify to make sure that I understand what your evidence this morning has been.

A. Yes.

Q. You have told me that at the time of the sign-out of the final autopsy reports, there was in your view no anatomical cause of death which you could pinpoint.

A. That is right.

Q. And that in fact is what your final report reads, and that is the report that went to the coroner?

A. Yes.

Q. Tell me, however, if it was your opinion as well at the time that the child had died of natural causes?

A. That is correct.

Q. And you felt, as I understood it, the contributing factors to be either congenital heart disease, or the implications of the collapsed





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left diaphragm; or I take it a combination of those two?

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A. That is correct, yes.

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Q. Your report however indicates, as we have suggested, that those were contributing factors and in terms of what you were able to report to the coroner you had to indicate you were not able to pinpoint the cause of death?

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A. Yes, I could not pinpoint the major type of cause of death.

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Q. Could you indeed even pinpoint a minor anatomical cause of death?

A. Well, I think there is only one cause, one major cause. But in terms of interpretation of findings which one had and then relating it to whether such findings would be responsible is sometimes for death very difficult to arrive.

What I would like to sort of just mention is that in determining the cause of death at autopsy we have some very obvious ones and then you have some which are difficult to be certain of, so that this one is in that category.

Q. And I take it, Doctor, that with respect to the possible contributing factor of





1  
2 congenital heart disease, that was not what you would  
3 term an anatomical finding. It was a disease and  
4 it was not something from an anatomical perspective  
5 that you could highlight as the cause of death?

6 A. No, that is an anatomical,  
7 because that is an examination of the structure,  
8 which is the heart, and the heart indeed was not a  
9 healthy heart. It had defects which were repaired,  
10 and it had areas of damage to the myocardium, but  
11 the extent of the damage was not extensive enough  
12 to consider it as a primary cause.

13 Q. Thank you, Doctor. Was that  
14 similarly true of the collapsed left diaphragm?

15 A. Well, the collapsed left  
16 diaphragm is more of a diagnosis, or type of a thing  
17 which one could see in a living patient. In other  
18 words, you see that the diaphragm doesn't move. That  
19 leads to a number of complications, as I mentioned  
20 before. So that is more of a clinical type of  
21 diagnosis. I cannot see at the time of death that  
22 the diaphragm is not moving because nothing is moving.

23 THE COMMISSIONER: I cannot see what  
24 about the diaphragm?

25 THE WITNESS: That the movement, the  
paralysis of the diaphragm refers to absence of





1  
2 movement in it, and this is something which one  
3 would observe in a living patient but it is not  
4 something that you can say that you see in a dead  
5 person, movement I am referring to.

6 THE COMMISSIONER: No, I see, yes.

7 MR. SCOTT: I suggest if you tried  
8 to sit back a little bit, because Doctor, insofar as  
9 you can.

10 THE WITNESS: All right.

11 MR. SCOTT: I know you are answering  
12 Miss Cronk's questions, but we do want to the  
13 Commissioner to hear directly what you say, so if you  
14 could try.

15 THE WITNESS: Okay.

16 MR. SCOTT: I am afraid Miss Cronk  
17 will have to tell him and then we don't know where  
18 we will be.

19 MS. CRONK: I will leave that one  
20 alone, Mr. Scott.

21 THE COMMISSIONER: I take it this  
22 collapsed diaphragm though, if you had not read  
23 about it in the medical reports, you couldn't in  
24 your autopsy, you couldn't even detect it, is that  
25 right?

THE WITNESS: That is correct.







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MS. CRONK: Q. That caused me a little bit of confusion, Doctor, because I would have thought, and perhaps I am wrong, that on a visual examination the body at gross autopsy, or as a result of microscopic examination of tissue samples, there would have been evidence present in a pathological sense which would indicate the existence of the collapsed left diaphragm. I take it that is incorrect?

A. Well, it is not, the term "collapsed" is not correct, it is paralysis.

Q. All right. Well, accepting the word paralyzed.

A. Yes.

Q. Are you saying then that there is nothing on autopsy in examination of the anatomy of the child that would indicate the presence of that condition to you?

A. That is correct.

Q. Do I take it then, Doctor, that there was nothing in your view in the child's anatomy at post mortem that explained why she died and when she died at the time that she did?

A. Well, that was one of the reasons that we put "undetermined", besides





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"anatomical cause: undetermined", and that was also the reason why I mentioned these two other things which might have been contributing factors, because I could not definitely prove it by anatomical examination, or pathology examination, but these were facts which were stated in the clinical chart.

Q. They were things then I take it, Doctor, that based on your observations you felt might have contributed to the child's death, but you are unable to say why she died based on the anatomical review that you conducted?

A. That is correct.

Q. Thank you, Doctor. May we turn then to the case of Phillip Turner. Once again, Doctor, as I understand it, you personally performed the autopsy on this child?

A. No, I did not. This was a Hospital case which was done by one of the residents who was with us at the time, Dr. John Srigley, and I supervised the autopsy.

Q. Thank you, Doctor. The child died on August the 1st, 1980, and as I understand it the autopsy was performed later on the same day, is that correct?

A. Yes, that is what the report





1  
2 indicates, yes.

3 Q. Doctor, prior to the gross  
4 autopsy, once again, Doctor, having regard to the  
5 involvement of the resident who actually performed  
6 the autopsy, did you have an opportunity to review  
7 the medical record of the child?

8 A. Yes, I would. Now, if I may  
9 just mention this, what happens when these autopsies  
10 are being done is the resident, the pathology  
11 resident would be the first to go through the chart  
12 in great detail, because he would be the one who  
13 would write the clinical summary to the report, and  
14 the staff pathologist would review it after the  
15 resident who briefs on the main findings, or the  
16 main problems, and there is a discussion between  
17 the pathologist and the resident, either to do  
18 certain things, or to look it up together. Then  
19 after this is completed, then the pathologist usually  
20 just leafs through the chart checking certain things.  
21 But prior to autopsy the pathologist does not  
22 necessarily do a detailed extensive review of the  
23 chart, which in some cases these charts are hundreds  
24 of pages long.

25 Q. I appreciate that, Doctor, it  
would not be done with the autopsy.





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2 In this case then, Doctor, were you  
3 briefed by the resident involved?

4 A. Yes, I was.

5 Q. And did you take what you  
6 described as a brief look at the medical record  
7 before autopsy?

8 A. Yes, I leafed through it, yes.

9 Q. Were you personally present  
10 while the gross autopsy was conducted?

11 A. I was present at certain times.  
12 In other words, I would walk in and out of the  
13 autopsy room, I was not present for the whole time.

14 Q. Following the gross autopsy,  
15 Doctor, on the basis of what was present and what  
16 was visually observed at that time, either by the  
17 resident, or by yourself, were you able at that  
18 stage, without more, to formulate an opinion as to  
19 cause of death of the child?

20 A. Yes. Well, at the completion  
21 of the gross autopsy I reviewed the findings with  
22 Dr. Srigley and there were obvious findings in terms  
23 of congenital heart disease which was a complex type.  
24 So the findings were basically similar to which were  
25 clinically suspected. So we confirmed the presence  
of the congenital heart disease and some changes







1  
2 which were visible on the gross autopsy and some  
3 other findings.

4 Q. Related to the congenital  
5 heart disease?

6 A. That is right.

7 Q. Other than those factors,  
8 Doctor, related to the congenital heart disease and  
9 the malformations that the child had in that  
10 connection, was there anything else that presented  
11 itself as a result of the gross autopsy as a possible  
12 cause of death?

13 A. Well, I think in this case,  
14 if I may read the main diagnosis which is  
15 hypoplastic left heart syndrome. It is one of the  
16 most severe types of heart anomalies and it is  
17 invariably fatal.

18 Q. Was that condition evident  
19 to you at gross autopsy?

20 A. That is correct.

21 Q. And if we turn again, Doctor,  
22 to Exhibit 124, at page 86, that is the final autopsy  
23 report on Phillip Turner, bearing as I understand it  
24 your signature and that of the - a space for the  
25 signature of the resident who actually performed  
the autopsy. As you have indicated - I am sorry,





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do you have that?

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A. I have my report. Page 86?

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Q. Page 86.

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A. I am afraid it is marked some-

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thing else.

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THE COMMISSIONER: You might not be  
reading the right document, it is Exhibit 124.

8

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MS. CRONK: Q. This one, Doctor,  
right here, excuse me. Having said that it seems  
that the pages are mixed up.

10

11

THE COMMISSIONER: It is 86 in mine.

12

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MS. CRONK: Q. Doctor, as you have  
indicated in the bottom section of the first page  
of the autopsy report, the anatomical diagnosis.

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A. Yes.

16

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Q. They are set out. The first  
and the predominant one as I take it is the condition  
you have already described and that is hypoplastic  
left heart syndrome.

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A. That is correct.

20

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Q. With a number of completing  
features and those are set out in that paragraph?

22

A. That is correct.

23

Q. And I take it as well,  
Doctor, that there was secondarily a finding of

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congestion in the lungs.

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A. That is correct.

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Q. And you have described that in

5

your report as moderate?

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A. Yes.

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Q. Thirdly, there was a finding

8

of congestion as well in the liver?

9

A. That is correct.

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Q. And again you have described

that as moderate?

11

A. Yes.

12

Q. And then fourthly there were

13

findings consistent with hypoxia.

14

A. Yes.

15

Q. And finally there was a

16

finding of periventricular leukomalacia, which you  
described as extensive.

17

A. Yes.

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Q. That is the same finding you

19

will recall that we saw in the case of Amber Dawson?

20

A. Yes.

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Q. On the basis of those patho-

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logical findings, Doctor, the completion of the

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autopsy and the sign out of the report, did you

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formulate an opinion as to what the predominant

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3 cause of death was for this child?

4 A. Yes, I think the last paragraph  
5 in the summary, the last sentence in the summary of  
6 the autopsy indicates that death was attributed to  
7 congenital heart disease complicated by ischaemic  
8 encephalopathy. So that in this instance, we have  
9 quite extensive anatomical changes in two sites  
10 which would be fatal independently or together.

11 Q. And what were they, Doctor?

12 A. The heart defect, the hypo-  
13 plastic left heart and the ischaemic encephalopathy,  
14 which basically means ---

15 Q. That was my next question,  
16 Doctor.

17 A. Destruction of brain cells in  
18 particular as a consequence of hypoxia or lack of  
19 oxygen.

20 Q. And I take it from you, that  
21 there was evidence of that condition following the  
22 microscopic examination of the brain tissue that  
23 was carried out?

24 A. Yes.

25 Q. At the time of sign-out of  
the report, having regarding to the fact that that  
was the opinion that you formulated, did you have







1  
2 any concern at that time as to whether or not  
3 digoxin had formed any part or contributed in any  
4 way to this child's death?

5 A. No, I did not, I had no concern.

6 Q. I take it then on the basis of  
7 the pathological findings which you have set out,  
8 you did not have any concerns as to why this child  
9 had died?

10 A. No, I did not.

11 Q. Thank you, Doctor. May we  
12 turn then to the case of Kevin Pacsai. This case,  
13 Doctor, - and Mr. Registrar, perhaps you would be  
14 kind enough, could you provide the Doctor with  
15 Exhibit 106, the medical records, and as well  
16 Exhibit 106A, which is the final autopsy report on  
17 Kevin Pacsai.

18 Doctor, we have heard in this case  
19 that once again this was the case that was reported  
20 to the coroner, and that the autopsy was conducted  
21 under the auspices of the coroner's offices. Did you  
22 personally perform this autopsy?

23 A. Yes, I did.

24 Q. And having regard to the fact  
25 that you personally conducted the autopsy, did you  
then personally review the medical records of the





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child prior to commencing the autopsy?

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A. That is correct.

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Q. Were you aware, Doctor, at

the time of conducting the gross autopsy, based on  
your review of the medical record, as to the  
antemortem digoxin levels which had been recorded  
in this case?

A. No, I was not.

Q. Prior to the gross autopsy,

Doctor, on the basis of your review of the chart,  
were there any features evident in the medical  
records of the child which suggested themselves to  
you at that time as a possible cause of death?

A. Well, the whole case was a  
puzzling one in that the clinical information I  
received, both talking to Dr. Fowler ---

In other words, Dr. Fowler  
calling me and there was, from my reading of the  
chart it didn't appear that it would be a straight-  
forward case. In other words, there would be some  
obvious cause of death from these findings.

Q. Did you speak to Dr. Fowler  
about this case before conducting the gross autopsy?

A. Dr. Fowler phoned me and told  
me about the case, saying that they had this child





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2 die and they are concerned about why this child died,  
3 and since they did not have a firm clinical diagnosis.  
4 The other problem he mentioned was that he had  
5 problems with the parents of the child.

6 Q. Other than those two factors,  
7 did Dr. Fowler alert you to, or draw your attention  
8 to any other features in the clinical history of  
9 the child?

10 A. No, he did not.

11 Q. So, Doctor, then on the basis  
12 of your discussion with Dr. Fowler, and on the  
13 basis of your own review of the medical record,  
14 you have told me it was a puzzling case and it didn't  
15 appear that there was an obvious cause of death,  
16 that it would be likely there was an obvious cause  
17 of death. Were there any features in the record of  
18 the child which struck you as important, which you  
19 had in your mind at the time you were conducting the  
20 gross autopsy?

21 A. Well, the further information  
22 I received was from the coroner, Dr. Tepperman.

23 Q. I see.

24 A. Who issued a Warrant in which  
25 he questioned some of the findings in the chart,  
particularly in relation to the potassium levels.





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Q. Anything else, Doctor?

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A. If I may look up the Warrant,  
it was a very brief one.

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Q. I take it then this was not  
on the basis of a discussion that you held with  
Dr. Tepperman prior to the autopsy?

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A. No, I did not talk to  
Dr. Tepperman.

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Q. This was on the basis of the  
Warrant that he had completed?

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A. No. He mentioned that they are fluctuating levels of potassium and a question mark why high levels of potassium if none was administered.

THE COMMISSIONER: None was what?

MS. CRONK: Administered.

THE WITNESS: None was given, none was administered.

THE COMMISSIONER: Oh, I see.

MS. CRONK. Q. All right. Then you have told us, Doctor, of your conversation with Dr. Fowler, of the question raised by Dr. Tepperman and the Coroner's Warrant. Was there anything in addition to those two factors which came to your mind on the basis of reviewing the medical record which suggested itself as a possible cause of death?

A. Well, not really as a possible cause of death but it suggested the possible areas to be investigated or looked into.

Q. And what were they, Doctor?

A. Well, from the clinical information it appeared that one of the initial diagnosis in this child was that he suffered from overwhelming infection which is a bacterial viral which would possibly affect his heart; another possibility mentioned





Cutz, dr.ex.  
(Cronk)

1  
2 was some conduction system disturbance and the third  
3 possibility which is mentioned I believe in two places  
4 was that of digoxin toxicity.

5 Q. When you say that it is  
6 mentioned in two places, I take it you mean it is  
7 mentioned in two places in the medical record of the  
8 child?

9 A. That's correct.

10 Q. All right. And were those  
11 then the factors that you had in mind at the time of  
12 commencing the gross autopsy?

13 A. Yes. I was considering these  
14 various factors: infection, the conduction system  
15 defect and the possibility of digoxin toxicity, yes.

16 Q. And I take it you had in mind  
17 as well the issue that had been raised by Dr. Tepperman  
18 about the potassium levels?

19 A. Well, the potassium levels,  
20 yes, obviously.

21 Q. All right. Doctor, we know  
22 that this child died at approximately 10:00 a.m.  
23 10:10 a.m. on March 12th and I note from the final  
24 autopsy report that the autopsy was not conducted  
25 until the following day on March 13th. Can you tell  
me at what time the autopsy was commenced?





1  
2 A. It was started about 24 hours  
3 after death.

4 Q. All right.

5 A. I would guess it would be in  
6 the morning between 10 and 12, something like that.

7 Q. All right. We have seen in  
8 a number of cases, Doctor, that the autopsies are  
9 conducted in respect of a particular patient on the  
10 very day that the patient died. Was there any reason  
11 in this case that the Pacsai autopsy did not take  
12 place until the 13th as opposed to the day of the 12th?

13 A. The possible reason - this is  
14 the time I was notified of the death was on the 13th.

15 Q. I see.

16 A. The 13th in the morning.

17 Q. And that I take it was by  
18 Dr. Fowler?

19 A. That was Dr. Fowler. We could  
20 only start the autopsy once the coroner has arrived  
21 and issued a Warrant. So that there might have been  
22 another delay for the coroner to come in.

23 Q. I take it then, Doctor, from  
24 what you have said that you did not see the Coroner's  
25 Warrant, nor learn of the child's death until the  
morning of the 13th?





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A. That's correct.

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Q. All right. Doctor, after the gross autopsy had been conducted we know and have heard evidence that this child had a structurally normal heart. Was there anything on the basis of the gross autopsy which concerns you with respect to the anatomical condition of the child's heart?

A. Well, the heart was anatomically normal which then excluded one possibility - that he had some undetected congenital heart defect which would be grossly visible.

Q. So, that was ruled out at that stage?

A. That was ruled out, yes.

Q. And at gross autopsy, Doctor, was there any evidence of the overwhelming infection about which there had been some suggestion during the life of the child?

A. Well, again, it's not something what you necessarily can determine by naked examination.

Q. I appreciate that, Doctor.

A. So that that doesn't rule it out.

Q. I appreciate that?

A. There is still that possibility.







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Q. But I take it then, based on the visual examination of the child, there was at that stage no evidence of infection?

A. Not that I could specifically say yes, I found the infection.

Q. Yes, all right. And as I understand it a number of microscopic studies were carried out in this case, a number of tissue samples taken?

A. That is correct.

Q. And were a number of cultures taken by virtue of the concern regarding infection?

A. Yes.

Q. And what were the results of those cultures when they came back?

A. The cultures came back negative, which is, if I might look up the dates, but they came up a few days or weeks later after the gross autopsy.

Q. All right. I take it then that on the basis of the results from the cultures that had been taken the possibility of infection was ruled out?

A. Well, once I received the results, yes.

Q. Yes, all right, Doctor. In





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1  
2 addition to the conduct of the microscopic examination,  
3 the taking of cultures for virology tests, as I  
4 understand it there was another set of tests that were  
5 done in respect of this child that related to digoxin?

6 A. That is correct, yes.

7 Q. All right. Can you help me,  
8 Doctor, as to who ordered the digoxin level on a  
9 postmortem sample in this case?

10 A. I.

11 Q. All right. Can you tell me,  
12 Doctor, why in this case you did that?

13 A. Well, as I mentioned, I tried  
14 to do a thorough autopsy covering the various  
15 possibilities and this appeared as one possibility.  
16 So, that was the only reason to actually do it.

17 Q. Prior to this case, Doctor,  
18 had you ever had occasion during any other autopsy  
19 that you conducted at the Hospital to order a postmortem  
20 digoxin level on a patient?

21 A. No, I had not ordered it but  
22 I also didn't have a case like Pacsai.

23 Q. Well, what was there about  
24 the Pacsai case that led you to order a postmortem  
25 digoxin level?

A. Well, the clinical history





7  
1  
2 of these various conduction disturbances, arrhythmias,  
3 problems with potassium are really minor or almost  
4 no anatomical findings.

5 Q. Was there anything else in  
6 the clinical history of the child, Doctor, that  
7 influenced you to order a postmortem digoxin level?

8 A. No, not really, nothing.  
9 That's based solely on clinical information.

10 Q. Well, I am trying to understand,  
11 Doctor, what the clinical information was that you  
12 regarded as significant in that regard and you have  
told me first about arrhythmias?

13 A. Yes.

14 Q. You have told me secondly  
15 about the conduction disturbances?

16 A. Yes.

17 Q. And you have told me about  
the problems with potassium?

18 A. Well, the potassium would  
19 not be a direct indication, would not be a major  
20 consideration for digoxin toxicity.

21 Q. All right.

22 A. But in certain situations it  
23 might be significant.

24 Q. All right. In terms then,  
25





Cutz, dr.ex.  
(Cronk)

1  
2 Doctor, of what your concern was, having reviewed the  
3 clinical history of the child, and you have told me  
4 about the arrhythmias and the absence of what appeared  
5 to be an anatomical cause and the conduction dis-  
6 turbances, were you concerned then at that stage that  
7 this child may have died from digoxin intoxication?

8 A. No, I was not. I submitted the  
9 sample to test it. I was not expecting it to come  
10 back sky high. I was aware of the level of digoxin  
11 taken in this child, which I knew was done in Hamilton  
12 and this level was within therapeutic range, I believe  
13 it was 1.9.

14 Q. You're talking now about the  
15 antemortem level that had been done at the referring  
16 hospital?

17 A. Yes.

18 Q. And you were not aware, you  
19 told me earlier, of any other antemortem levels that  
20 had been taken?

21 A. Not at our Hospital.

22 Q. All right. Doctor, you have  
23 told me that prior to this case you had not had occasion  
24 to order a postmortem digoxin level. To your knoweldge  
25 in the Pathology Department, had any of your colleagues  
had occasion to order a post mortem digoxin level







Gutz, dr.ex.  
(Cronk)

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prior to this case?

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A. Not that I am aware of.

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Q. All right. Were you then aware at the time of dealing with the Pacsai child, that a post mortem digoxin level had been ordered on Janice Estrella?

7

A. No, I was not.

8

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Q. All right. Can we turn then, Doctor, to the sample itself that was taken on Kevin Pacsai. I take it because you performed the autopsy, would I be correct that you personally took the sample?

12

A. That is correct, yes.

13

Q. All right. Can you tell me what the sample was?

14

A. The sample was blood.

15

Q. All right.

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A. Which was taken from inferior vena cava, which is the vessel entry the right side of the heart and it is entering from the liver.

18

19

Q. Right.

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A. So, it is the connection between the rest of the body and the heart where the blood enters the heart.

22

23

Q. All right. I take it that is a vein, Doctor?

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A. Yes.

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Q. All right. Was there any

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particular method that you used to draw that sample?

5

How did you physically take the sample?

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A. No, not a particular method.

7

I mean, a sample was taken from culture from the same

8

site and this is the usual site I take samples for

9

blood cultures. This is done early on when the body

10

is opened so that there is a minimum of contamination.

11

Q. All right. Doctor, may I

12

examine that for a moment with you. You told us that

13

the autopsy you think was commenced some time between

10:00 a.m. and 12 noon of the 13th of March?

14

A. Yes.

15

Q. Can you help us as to when the

sample itself was drawn?

16

A. Well, that would be taken

17

early on during the autopsy in the early stages of

18

it.

19

Q. All right. At the time of

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taking the sample had any dissection of the body

21

actually been commenced?

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A. Well, what you have to do

is, obviously, open the chest cavity.

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Q. Yes.

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A. So, this is what was done first. After the chest cavity is opened, after dissection of the pericardial sac which covers the heart then it is then when the sample is taken.

Q. And in this case is that when the sample was taken?

A. That is correct.

Q. Doctor, we have heard evidence regarding a number of ways in which a blood sample can be taken, either ante mortem or post mortem. Can you help me now as to how you actually physically drew the blood sample in this case?

A. Yes, this is done with a needle and a syringe. The site where the puncture is made is sterilized. This is for the purposes of culture. We just insert the needle and aspirate the material into the syringe.

Q. All right. And when you say you insert the needle, do I take it then that it was inserted directly into the inferior vena cava vein?

A. That's correct.

Q. All right. Was there in your mind, Doctor, at the time that you took the sample any risk of contamination from either artifacts





12  
1 surrounding the sample site or from any other materials  
2 that were then evidenced?

3  
4 A. Well, not in terms of  
5 contamination from other sources, no.

6 Q. All right. Well, was there  
7 in your mind any risk of contamination by any means  
8 with respect to that sample?

9 A. Would you rephrase that, I  
10 am not really sure what you mean.

11 Q. That's fair, Doctor. You have  
12 told me that there was not in your mind a risk of  
13 contamination from any other source?

14 A. Yes.

15 Q. Did you have any other concern  
16 at the time of drawing the sample that it might be  
17 contaminated?

18 A. I wouldn't think it would be  
19 contaminated because except for the chest nothing else  
20 has been opened yet.

21 Q. All right.

22 A. And the concern of taking such  
23 a sample, as I indicated, would be for purposes of  
24 bacterial cultures. So that what you are concerned  
25 mostly is with bacterial contamination, that is,  
bacteria from the surrounding air.







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Q. Right.

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A. So, you sterilize the surface and that's how you enter it. So, this is the main concern in terms of contamination is bacterial contamination.

Q. How do you physically sterilize the surface, how did you in this case?

A. Well, the surface is sterilized with a warm or hot instrument.

Q. And you press that against the site from which you are going to draw the sample?

A. That's correct, yes.

Q. All right. Mr. Registrar, could the Doctor be shown Exhibit 32A if you would, please.

Doctor, this book is a volume of exhibits that were introduced at the preliminary hearing in The Queen versus Nelles and I would ask you to turn to Tab 44 if you would.

A. Yes.

Q. Do you have that, Doctor?

A. Yes, I do.

Q. That is a form, as I take it, a form of requisition for the biochemistry laboratory in the Hospital, the Clinical Chemistry





1  
2 Division. It appears to be Sample No. D-57970 in  
3 the name of Kevin Pacsai. It is a request for a  
4 digoxin assay and on the right-hand side of the page  
5 at the bottom there appears to be a signature and I  
6 take that to be yours, is that correct?

7 A. Yes.

8 Q. Is this the requisition form  
9 that you completed for the digoxin assay on Kevin  
10 Pacsai?

11 A. Yes.

12 Q. Thank you, Doctor. I take it,  
13 Doctor, that at some subsequent point the results of  
14 the assay were reported to you?

15 A. Yes.

16 Q. All right. Can you tell me  
17 when you learned of the results of the digoxin test  
18 that you had ordered?

19 A. Yes, I learned about the  
20 results on March 18th when Dr. Costigan phoned me.  
21 I believe it was in the morning some time between  
22 9 and 10. He told me that a high level of digoxin  
23 was found in a sample of blood from the patient  
24 Pacsai. He also told me that he was referring to  
25 my sample which I sent and he also told me that he  
took a sample from the same patient either shortly





1  
2 before or shortly after death, I'm not certain about  
3 the timing, which reveals similar amounts.

4 Q. Did he tell you expressly what  
5 the level was that had been reached on your sample?

6 A. I can't be certain whether he  
7 told me a number but surely he said it was a high  
8 level.

9 Q. All right. And did he tell  
10 you specifically what the level was that had been  
11 obtained on his sample or did he merely indicate that  
12 it was a high level?

13 A. No, he just said it was  
14 similar to what it was in the sample I sent.

15 Q. All right. Do I take it  
16 then, Doctor, that prior to the phone call which you  
17 received from Dr. Costigan you had not been contacted  
18 in any way by the Biochemistry Department to inform  
19 you as to the results of that level?

20 A. No, I had not.

21 Q. All right. Did Dr. Costigan  
22 express any concern to you with respect to those  
23 levels during your discussion with him?

24 A. Well, I just had a brief  
25 conversation with him and I can't really recall  
whether any particular concern was expressed or any





1  
2 particular reasons for this high level were discussed.

3 Q. All right. Doctor, you have  
4 the record before you, page 91 of the medical record  
5 of Kevin Pacsai indicates that the level obtained on  
6 Sample No. D-57970, that is the sample number on the  
7 requisition form which you completed, resulted in a  
8 level of 26 nanograms. Can you help me, Doctor.  
9 Does that biochemistry report help you or assist you  
10 in any way in recalling whether or not you knew on the  
11 18th what the exact level was on the postmortem sample?

12 A. Yes, I learned about the  
13 exact level later on that day, but I can't recall whether  
14 it was Dr. Costigan, Dr. Fowler or Dr. Ellis, but I  
15 heard the level, the number during the day.

16 Q. All right. I take it then  
17 that on the same day you spoke to Doctors Fowler and  
18 Ellis in addition to Dr. Costigan?

19 A. That's correct.

20 Q. When did you speak to Dr.  
21 Fowler?

22 A. Well, Dr. Fowler shortly after  
23 I had the conversation with Dr. Costigan he came down  
24 to my office and told me again the same thing that  
25 Costigan mentioned, it was the high level of digoxin  
found in the blood samples.







17 1  
2 He came to see me to review the  
3 chart of Pacsai, which I had at the time. So, I  
4 handed the chart to him and he was reviewing it.

5 He also told me that they are  
6 checking, or he wanted to check in the chart the  
7 dosages of digoxin given to the child and he has to  
8 report this or has to have the information for the  
9 Risk Management Committee which apparently is in-  
10 vestigating this incident.

11 Q. Did you, after your discussion  
12 with Dr. Costigan call or seek out Dr. Fowler in  
13 any way or did he seek you out?

14 A. He came to see me, yes.

15 Q. And did Dr. Fowler indicate  
16 any concern or reaction to you with respect to the  
17 high level that had been found on those samples?

18 A. Yes, I think he was disturbed  
19 about it. As I mentioned, I handed the chart to him  
20 and then he went to the next room to look at it. So,  
21 I did not have much long a conversation with him.

22 Q. All right.

23 A. About it.

24 Q. Prior to Dr. Fowler arriving  
25 at your office and requesting the medical record, I  
take it that you have told us that was some time after





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you had spoken to Dr. Costigan. Do you recall how long it was after you had spoken to Dr. Costigan?

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A. It was about 20 minutes to a half an hour, something like that.

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Q. All right. Between the time that you concluded your discussion with Dr. Costigan and the time when Dr. Fowler arrived, did you yourself review the medical record of the Pacsai child?

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A. I might have, yes.

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Q. Do you recall doing so?

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A. No, I'm not certain if I did or not.

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Q. All right. And you mentioned as well, Doctor, that you had a discussion that day with Dr. Ellis?

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A. Yes. Dr. Ellis came to see me early afternoon the same day and he told me again, saying that the high level - he came to talk to me about this high level of digoxin in the sample. He came to ask me specifically if there would be a sample of heart muscle available for analysis to determine or compare the levels in the serum versus the one in the heart muscle, to sort of give some explanation, possible explanation of this high blood

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Cutz, dr.ex.  
(Cronk)

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level.

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Q. All right. And was there a  
sample of heart muscle available?

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A. No, I had not specifically  
saved a sample for toxicology purposes but I did save  
a sample for virological investigation, which was sent to  
virology. So, I told him that he should check with  
virology if such sample is still available.

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Q. By the time of your discussion with Dr. Ellis, doctor, as best you can recall it today, were you then aware of what the actual level was on Kevin Pacsai?

A. Yes.

Q. Prior to Kevin Pacsai's case, had you ever had experience with, or heard of, a level of 26 nanograms for digoxin in a child?

A. No, I had not.

Q. Other than the request made by Dr. Ellis of you for a heart muscle specimen, did you have any other discussions with Dr. Ellis regarding that level at that time?

A. Yes. I was asked -- I had discussions regarding as to how one should interpret this result, and I was asking him specifically about the assay to see, in terms of, you know, whether there was a possibility of an error in the assay and whether they should not re-check these things. He indicated to me that it had been re-checked and they feel quite confident this is a true result.

Q. That is what he indicated to you when he saw you on the 18th?

A. That is correct.







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Q. Other than the possibility of an error in the assay, doctor, did you have any other concerns as to whether or not that level was valid or reliable, when you heard what the level actually was?

A. Yes. If one was to accept that as being a fact, then one has to think of the possibilities; how could this be possible. One of the first things which occurred to me was the possibility of a medication error; in other words, a patient being given too much of the drug and, in particular, the possibility of a decimal error in which an error is made in the prescription in which, possibly, you could get levels 10 or 20 times what would have been prescribed.

Q. Did you discuss that possibility with Dr. Fowler?

A. No, I did not.

Q. Did you discuss that possibility with Dr. Ellis?

A. I cannot remember whether I did, but we discussed some aspects as to how could this level be possible.

Q. I take it then, doctor, that when you heard of the actual number involved, the





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level itself, you were concerned first that there might be some error in the assay which had been performed. Do I have that correctly?

A. Yes.

Q. And you were assured by Dr. Ellis in that regard, that that did not appear to be the case?

A. Yes.

Q. And you had a concern as well that there might be a medication error, some transcription error, when the drug was prescribed and administered to the child?

A. That is right.

Q. After learning of the level, did you make any enquiries to determine whether or not there had been a medication error of any kind?

A. I think I reviewed the chart prior to autopsy and I did not seem to find any error. Afterwards, I reviewed it again and I did not seem -- there was no apparent error, to me.

Q. All right. Thank you, doctor.

In terms of the level itself, you have told us that you spoke about it, with





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Drs. Costigan, Fowler and Ellis during the course of the day on the 18th. Did you have occasion subsequently to discuss the matter with Dr. Mancer?

A. Yes. Because it was bothering me and puzzling me as to how to explain the level, I sought some advice. I went to see Dr. Mancer to ask him whether he might possibly know something about post mortem digoxin levels and to ask him whether he might have previous experience with this. I consulted with him on previous occasions on different other things, particularly relating to medical/legal cases, such as cases of child abuse. Likewise, Dr. Mancer would consult with me on certain things.

Q. When did you consult with Dr. Mancer?

A. This was on the 20th.

Q. Stopping there for a moment, from March 18, when you learned of the level and discussed it with Drs. Fowler, Costigan and Ellis, and March 20, when you sought out and discussed it with Dr. Mancer, did you have any other discussions with any of your colleagues in the Pathology Department with respect to this level?

A. No, I did not.





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Q. You have told us that you met with Dr. Mancer and discussed the level on the 20th of March. What did you tell him at that time?

A. I did not exactly meet him. I sort of -- in other words, I did not have a meeting with him.

Q. I understand.

A. Could you repeat the question?

Q. What did you tell Dr. Mancer when you spoke with him about this level on the 20th of March?

A. I told him that I had this unusual case with a high digoxin level and asked him whether he knows of any similar case or has any experience with post mortem levels of digoxin.

Q. What was Dr. Mancer's reaction when you told him of the level?

A. He said he, in fact, has a case where there is a very high digoxin level and he mentioned that, in his case, they are not certain what it meant; that they were considering it a lab error.

Q. I take it that was the case of Janice Estrella?







Cutz  
dr.ex. (Cronk)

CC6

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A. Yes.

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Q. And did he mention to

4

you both the level itself on Janice Estrella and the  
name of the patient, in your discussion?

5

6

A. I think he might have  
mentioned the level, which was considerably more than  
the result I had on Pacsai. I am not sure whether  
he mentioned the name.

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Q. Having learned from Dr.

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Mancer of his experience on the Estrella case and  
another high level and knowing the level that had  
been obtained on Pacsai, did you have any additional  
or other concerns when that additional piece of  
information was provided to you?

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A. I think the information  
he gave me, particularly the interpretation of that  
result as being a lab error, reconfirmed my informa-  
tion that even my case must be some kind of either  
laboratory error or some post mortem artefact.

Q. During the discussion that  
you had with Dr. Mancer, was there any discussion  
about the reporting of the Estrella case to the  
Coroner? Did that come up during your discussion?

A. He mentioned that his  
case has not been so far reported because they did not  
know how to interpret it or what the significance of





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it is and, when I told him about my case, he mentioned that this would be reported to the Coroner; that he is going to report it.

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Q. Doctor, on the basis of what Dr. Mancer told you was the concern with respect to the level on the Estrella child, and that is the possibility of an error, did you, after your discussion with Dr. Mancer, meet with, or discuss the case again with anyone from the Biochemistry Lab at the Hospital to determine whether or not there had been an error in the case of Kevin Pacsai?

12

A. Not at that time.

13

14

15

Q. When you learned of the level on the 18th of March, did you have any discussions thereafter with Dr. Tepperman of the Coroner's office with respect to the level?

16

A. No, I did not.

17

18

19

Q. To the best of your knowledge, had the level been reported to him by the time that you were informed of it by Dr. Costigan, or do you know?

20

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A. My impression, in talking with Dr. Costigan and Dr. Fowler, and knowing that they were in communication with Dr. Tepperman, was that he had been told by them about the report.





CC8

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Q. I see.

3

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A. Another thing, during my discussion with Dr. Ellis, I mentioned to him that I would need a written report of his result with a copy to me and one copy to Dr. Tepperman.

5

6

7

Q. Did you subsequently receive a written report from Dr. Ellis?

8

9

A. Yes. I received it later on.

10

11

12

Q. And is that the Biochemistry computer printout that we see at page 91 of the medical record?

13

A. Yes, that is it.

14

Q. Thank you, doctor.

15

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Doctor, you have told us that, with respect to the autopsy itself on Kevin Pacsai, a number of microscopic examinations were carried out, a digoxin level was ordered by you and the results came back on the 18th. Other than those two test procedures, were any other tests conducted as part of the autopsy on Kevin Pacsai?

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A. Yes. We took samples of fluid from the eye.

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Q. For what purpose?

A. To test the electrolytes,





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particularly potassium and sodium chloride.

Q. Dealing first with sodium, doctor, what were the results of the test?

A. What was the page number?

Q. Doctor, perhaps I can put it to you this way: When the results from the electrolytes test for sodium were available to you, was there anything unusual about that level?

A. No, it was one fifty three milliequivalent/litre, and this is within the normal range of post mortem sodium.

Q. So, you had no concern about that level?

A. That is correct.

Q. Other than potassium, leaving that aside - and I will come back to that in a moment - were any other test results on electrolytes available to you?

A. There were test results done during life.

Q. I'm sorry, I meant post mortem tests that you had ordered.

A. No. No other tests.

Q. Dealing with the question of potassium level, doctor, can you tell me what the







1  
CC10 2 level was that was reported to you as a result of  
3 those tests?

4 A. It was 11.6.

5 Q. 11.6, in what form of  
6 measurement?

7 A. Milli equivalent per litre.

8 Q. Can you tell me, doctor,  
9 was that high or low or normal, in your view?

10 A. This level would be high  
11 in a living person but, 24 hours after death, this  
12 would be within the normal range, what you expect.

13 Q. I take it, doctor, then,  
14 when that level was reported to you, it did not cause  
15 you any concern?

16 A. No.

17 Q. Did you have any explana-  
18 tion, based on the conduct of the autopsy and the  
19 anatomical condition of the child, doctor, for why  
20 the level was 11.6?

21 A. There was indication in  
22 the clinical history and the results that the child  
23 had disturbances or fluctuation in the potassium  
24 levels, going from a low of, I believe, 3.6 to a  
25 high of 7.7.

Q. These were the levels





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during life?

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A. That is right.

4

Q. So, there was a variability,

5

then, in potassium levels that had been recorded on  
Kevin Pacsai when he was alive?

6

A. That is right.

7

Q. Did that have any signi-

8

ficance to you in interpreting the level of 11.6

9

that came back post mortem?

10

A. The 11.6, as mentioned earlier,

11

in the post mortem sample, especially if it is 24

12

hours after death, is of no particular significance

13

because there is release of potassium from cells

14

and it is cumulative over a time period.

15

So that, if he had a level of

16

5 or 6, that would gradually be starting to increase;

17

so, he might have had an elevated level or a normal

level and, at the post mortem, it shows 11.6.

18

Q. We know, doctor, that

19

the interval between the time of the child's death

20

and the time of the autopsy, you said was approximately

24 hours; that is, the next day.

21

A. That is right.

22

Q. Is that the time interval

23

that you are referring to?

24

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A. That is correct.

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Q. And you told us as well

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that potassium releases from the cells, I take it,  
after death.

5

A. That is correct.

6

Q. And knowing that, it was

7

on that basis, I take it, that the number caused you  
no particular concern?

8

9

A. That is correct.

10

Q. Doctor, may we turn then

11

to the final autopsy report on Kevin Pacsai, which  
is Exhibit 106A, and copy has been provided to you,  
I think.

12

13

Do you have that, doctor?

14

A. Yes.

15

Q. If we turn to page 2 of

16

the final autopsy report and the final paragraph, where,  
I take it, the summary of your findings is set out,  
the first finding appears to be confirmation that the  
heart was anatomically normal?

17

18

19

A. Yes.

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Q. Your introduction is that

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generally, there were no significant anatomical findings  
present at autopsy.

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A. That is correct.

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Q. If we continue -- I'm sorry, you should have in front of you as well, doctor, the preliminary autopsy report, which is found at page 94 of the medical record. Perhaps you could keep the two side-by-side.

Do you have that, doctor, preliminary autopsy report, page 94?

Dealing with the last paragraph in the preliminary autopsy report, doctor, we see that the first two indications are those which are also recorded in the final autopsy report; namely, first, that there were no significant anatomical findings present at autopsy and, secondly, the heart appeared to be anatomically normal.

The two reports are consistent in that regard?

A. That is correct, yes.

Q. Dealing with the preliminary autopsy report, we see the entry that the conduction system had not yet been examined.

When I look at the final paragraph on the final autopsy report, I see no mention of a study of the conduction system.

Can you tell me, doctor, at the time of preparing the preliminary autopsy report, was







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it your intention to carry out a study of the  
conduction system on Kevin Pacsai?

A. Yes, it was.

Q. For what purpose, doctor?

A. As I mentioned earlier,  
the possibilities which may account for this clinical  
presentation should include a study of the conduction  
system.

Q. Did you intend to do  
that; carry out that study yourself, doctor?

A. This would be an extensive  
and lengthy study in which one has to almost serially  
section the heart, which would give you some 20,000  
sections; so, it would require several months' study  
and work to completely rule out an abnormality in the  
conduction system. So, this is a very thorough way.

Now, it would be a simpler way  
to sample just parts of the conduction system and see  
if there is anything obvious, which would involve maybe  
a few hundred sections. This, I could have done myself,  
or I could have asked for help from some cardio-  
vascular pathologists who have done this kind of work.

Q. When we turn, then, to  
the final autopsy report, doctor, and we see no mention  
of the conduction study, had you changed your mind





1  
CC15 2 by the time you completed the final autopsy report  
3 or had the conduction study, in fact, been undertaken  
4 and completed?

5 A. No. The study was not  
6 done because of subsequent events, which was that  
7 the heart tissue which was available had been used  
8 for toxicology examination.

9 Q. Doctor, you told me  
10 that, without a conduction study, as I understand it,  
11 you could not rule out the existence of an abnormality  
12 in the conduction system of Kevin Pacsai.

13 Do I have that correctly?

14 A. One cannot be absolutely  
15 certain that this was not the case.

16 Q. In respect to the cause  
17 of death in this child, is that then still, in your  
18 mind, a possibility?

19 A. In view of the level of  
20 digoxin, that makes it more complicated in terms of  
21 saying that this is the cause.

22 Accepting the digoxin level as  
23 being the true level, I think that would take prece-  
24 dence over the conduction problem. The conduction  
25 defect might have been responsible for presenting  
symptoms; that is, the symptoms he had two or three





CC16

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days prior to death. That would explain that.

3

Q. I see.

4

A. It might have explained his death but it would not have explained the high digoxin value.

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Q. Doctor, there was mention in both the preliminary and final autopsy reports as well of congestion, which you found to be present at autopsy in a number of organs; the liver, the spleen; the lungs.

11

In your view, were those findings sufficient to account for the child's death?

12

13

14

A. Those would not be causes of death. Those would be findings consistent with cardiac failure.

15

16

17

Q. And there is mention as well of evidence of hypoxia present, you indicate, and mention hemorrhage of the thymus.

18

19

Once again, was that finding, doctor, in your view, sufficient to account for the child's death?

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A. No.

Q. I take it then, doctor, that, on the basis of the summary that is contained in both your preliminary and final autopsy reports, you





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had been successful in ruling out viral infection by virtue of the results that had come back from the cultures; is that correct?

A. Yes.

Q. You had been successful in ruling out any anatomical malformation of the heart as being the cause of death of the child?

A. Yes.

Q. As well, you had not regarded the test results on the electrolytes test as being significant in terms of cause of death of the child?

A. That is correct.

Q. You were left, however, with the question of some potential abnormality in the child's conduction system?

A. That is correct.

Q. But, in the final analysis, you were confronted with a digoxin level of 26 nanograms?

A. That is correct.

Q. You have indicated, doctor, in respect to that level, in both reports, your predominant finding is "digitalis toxicity"?

A. That is correct.

Q. Do I take it, doctor, that,







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at the time of preparing the preliminary autopsy  
report and at the time of sign-out of the final autopsy  
report, it was your conclusion that that was the  
cause of death of this child?

A. That is correct.

MS. CRONK: Mr. Commissioner, should  
we break?

THE COMMISSIONER: We will take  
fifteen minutes.

--- recess.





D/DM/ak

1  
2 ---Upon resuming.

3 MS. CRONK: Q. Doctor, before the  
4 break I had referred you to both the preliminary and  
5 the final autopsy reports on Kevin Pacsai. With  
6 respect again to both, and specifically to page 2 of  
7 the preliminary autopsy report, there is indication  
8 that one of the findings that was evident at autopsy  
9 was an old infarct with an area of fibrosis and  
10 calcification in the section of the left kidney.  
Do you recall that finding?

11 A. Yes, that is correct.

12 THE COMMISSIONER: That is not on my  
13 page.

14 MS. CRONK: Is it not, sir.

15 THE COMMISSIONER: Page 95.

16 MS. CRONK: Page 95. I'm sorry, it is  
17 on page 94, sir, Item No. 6 under "Anatomical  
Diagnosis".

18 THE COMMISSIONER: Oh, yes, I see.

19 MS. CRONK: Q. Can you tell me,  
20 Doctor, what significance, if any, that you attach  
21 to that finding?

22 A. Well, the finding would not  
23 be significant enough to really cause any renal  
24 problems, or would certainly not be considered to  
25





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2 be related to causing death.

3 Q. I see.

4 A. And basically it involves a  
5 lesion in the kidney which was a small part of the  
6 kidney, which becomes sort of dysfunctional, just  
7 a small portion of it, perhaps as a result of some  
8 event early in life, maybe even in utero, where  
9 perhaps a thrombus, a plugging of a vessel may cause  
10 damage to part of the kidney and then the scars  
11 start, it forms a scar.

12 Q. Is that condition then, or  
13 that finding, Doctor, would that be representative of  
14 a form of tissue death, death of the cells of the  
15 tissue?

16 A. Yes, but that would be something  
17 which would have occurred a long time ago.

18 Q. Doctor, based on the full  
19 autopsy that you conducted and that you have  
20 described, were there any pathological findings,  
21 which in your view suggested or indicated kidney  
22 malfunction, or dysfunction, in this child?

23 A. No, they were not detectable  
24 by the anatomical methods.

25 Q. And Doctor, I take it as well,  
having examined both the reports that you as well





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examined the adrenal glands of this child.

3

A. That is correct.

4

Q. And if we turn to page, because

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I want it, I won't be able to put my hand on it:

6

I am sorry, page 3 of the final autopsy report, that

7

is page 3 in accordance with the numbering of the

8

report itself.

9

A. Correct.

10

Q. We find there your weight  
measurements.

11

THE COMMISSIONER: I'm sorry, that is

12

page --

13

MS. CRONK: I'm sorry, the final

14

autopsy report, sir, is Exhibit 106A, I don't think

15

it is formally part of the child's medical record.

16

Sir, if you would turn to page

17

98 of the medical record, that is easier, it is

18

also found there.

19

THE COMMISSIONER: Yes, all right.

20

MS. CRONK: Q. Doctor, under sub-

21

section (f) we find there the findings with respect

22

to the weight of the adrenal glands that you made  
at autopsy.

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A. Yes, that is correct.

24

Q. Can you help me, Doctor, was

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there, on the basis of the autopsy and the post mortem results, any abnormality noted in the size or the shape of the adrenal glands in this child?

A. No, there was not.

Q. Was there any abnormality noted anatomically in any other respect with respect to these glands?

A. No, they appeared to be normal.

Q. Doctor, are you aware that in the summer of 1982, Dr. Bain of your Hospital prepared a report with respect to a number of the children that this Commission is concerned with, including Kevin Pacsai?

A. Yes, I am aware of that report.

Q. Have you had occasion to review Dr. Bain's report?

A. No, I did not.

Q. Doctor, to assist you, Mr. Registrar, that exhibit is No. 48.

Doctor, I would ask you to turn to page 27 if you would of Dr. Bain's report. Do you have that, Doctor?

A. Yes.

Q. You will see in the middle





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3 section of the summary set out on the page the  
4 following:

5 "The diagnosis which immediately comes  
6 to mind is acute adrenal insufficiency.  
7 The commonest cause of this in Kevin's  
8 age group is the adrenogenital syndrome,  
9 but this was ruled out by the finding  
10 of normal sized adrenal glands.

11 The second cause is Addison's Disease,  
12 but again microscopic examination of  
13 the adrenals did not reveal such a  
14 condition. However transient adrenal  
15 insufficiency is a very well recognized  
16 syndrome in this age group and there is  
17 another case report of a similar series  
18 of events related to milk intolerance."

19 Doctor, are you familiar with the  
20 condition described as transient adrenal insufficiency?

21 A. I am familiar with it in the  
22 context of that being the clinical diagnosis.

23 Q. Have you had any experience  
24 with it in terms of the autopsies on various patients  
25 that you have conducted in the course of your  
association with the Hospital for Sick Children?

A. No, I did not.





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Q. Doctor, based on your experience in pathology and you may not be able to answer this question, but if you are it will be of assistance. Based on your experience at the Hospital, and in conducting many autopsies and the knowledge that you do have of this condition, would you expect any anatomical indicators or markings to be evident at post mortem if that condition existed in a patient?

A. Well, I think as the name implies, otherwise if it was known what the cause of it is, it would have a different name. I assume the name "transient adrenal insufficiency" would indicate that this is something which happens in life and then it comes and goes kind of, and you could possibly diagnose this by measuring say the hormones which are produced by adrenal and noticing some changes; plus changes in the patient. But this is not something that you necessarily would see by examining the adrenal gland, especially at autopsy.

Q. Doctor, I take it then that based on your experience and knowledge, it may well be that the condition could exist but there there would be no pathology indications in that at autopsy?

A. That is correct.

Q. Doctor, are you familiar with,





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and I ask you this question generally; are you familiar with any literature in the field of pathology or histology which deals with the pathology of this condition?

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A. No, I am not.

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Q. Thank you, Doctor. Then finally, Doctor, you indicated earlier that when Dr. Ellis came to see you on March 18th, and discussed with you the digoxin level that had been obtained in respect of Kevin Pacsai, he asked you whether or not you had a sample of heart muscle, I believe you told me that would be available for testing?

14

A. That is correct.

15

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Q. And if I understood what you told me correctly, you said that he indicated to you that he wanted that sample for the purposes of hopefully being able to compare the level of the serum versus the level in the heart muscle, have I got that correctly?

20

A. That is correct.

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Q. To the best of your knowledge, Doctor, were digoxin assays of any kind subsequently run by the Hospital's biochemistry laboratory in respect of heart muscle tissue?







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A. I know that the assay which is set up for measuring digoxin in fluids has been used, but the tissues would require modification of the method. As far as I am aware this has not been done.

Q. Were you informed subsequently, after March 18th, Doctor, of any efforts made by Dr. Ellis, or any of his colleagues in the Biochemistry Department, to run assays for digoxin on tissue samples from Kevin Pacsai?

A. No. My knowledge of it as far as these tests on digoxin goes, that after these cases came to light the testing has been referred to the Centre for Forensic Sciences.

Q. I take it then, Doctor, you do not have any knowledge as to any tests which may or may not have been conducted at the Hospital on tissue samples for Kevin Pacsai?

A. No.

Q. Thank you.

Doctor, you have told us what your opinion was as to the cause of death of this child; and you have told us of the circumstances under which you were informed of the digoxin level that was obtained post mortem on Kevin Pacsai. When you





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2  
3 learned of that level, and when you knew that the  
4 level was 26 nanograms, can you tell me, Doctor,  
5 did you lend your mind as to the method whereby that  
6 level might have resulted in this child?

7 A. Well, obviously, I was puzzled  
8 by having to have to explain, trying to explain this  
9 kind of a level. The only thing which went through  
10 my mind was that there might be some scientific  
11 explanation for it, and that we should be looking  
12 into possible ways to rule out how this level can  
13 occur.

14 Q. Did any scientific explanation  
15 present itself to you?

16 A. Not at the time.

17 Q. And Doctor, you have told me  
18 that during the course of your discussion with  
19 Dr. Mancer on March the 20th, you knew first that  
20 the level on Kevin Pacsai was 26 nanograms, and you  
21 were informed as well as to the level on Janice  
22 Estrella?

23 A. Yes.

24 Q. When you learned of both of  
25 those levels, Doctor, did you at that time have any  
cause, or did you consider that there may be something,  
to put it bluntly, sinister afoot with respect to





DD10

1  
2 the deaths of those two children?

3 A. No, I didn't think it was  
4 sinister.

5 Q. I take it then, Doctor, that  
6 insofar as you were concerned at the time you thought  
7 there might be some scientific explanation for the  
8 level with respect to Kevin Pacsai, but you didn't  
9 know what that might be?

10 A. That is correct.

11 Q. Thank you, Doctor. May we  
12 turn next then to the case of Kristin Inwood. The  
13 medical record is Exhibit 113, Mr. Commissioner.  
14 This child he died on March 13th, 1981. We have  
15 heard that the autopsy was performed on that day.

16 Can you help me, did you perform the  
17 autopsy itself, or did you supervise others in the  
18 conduct of the autopsy?

19 A. No, I did not do the autopsy,  
20 neither did I directly supervise it.

21 Q. Doctor, could you turn if you  
22 would to page 20 of the medical record, the medical  
23 record of Kristin Inwood?

24 A. Yes.

25 Q. At page 20.

A. Yes.





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Q. We have there the final autopsy report that was prepared. I note that your signature appears on the bottom left hand side of the page, is that correct?

A. That is correct, yes.

Q. Can you help me, Doctor, if you neither performed the autopsy, nor supervised others in its performance, why is it that your signature appears on the final version of the autopsy report?

A. Under the signature it says: "For Dr. M.J. Phillips", who was the primary pathologist responsible for supervision of the case. The report was completed in a period between March 24th and 25th in a time that Dr. Phillips was away, and the purpose of the completion of these reports was because this particular case was under suspicion.

Q. Doctor, when you say it was completed, are you referring to the final autopsy report?

A. The report and the investigation of the case in terms of the pathology has been completed to a certain stage. In other words, the gross autopsy would have been completed, the history;







DD12

1  
2 summary of the history would have been written out;  
3 and two parts which were missing was the microscopic  
4 examination and the examination of the brain.

5 Q. Well, Doctor, just so I have  
6 some understanding as to what the time frame is. You  
7 have told me that the final autopsy report, I think  
8 you were referring to the final autopsy report, was  
9 completed in that two day period, March 24th and  
10 March 25th?

11 A. That is correct.

12 Q. Was the preliminary autopsy  
13 report completed and signed by the time you had any  
14 involvement with this case?

15 A. I believe so.

16 Q. And if we turn to the preliminary  
17 autopsy report, which is found at page 36 of the  
18 medical records, we see that the history section of  
19 the report was completed; the section provided for  
20 clinical diagnosis; and similarly the section for  
21 anatomical diagnosis, all were completed?

22 A. That is correct.

23 Q. And you have told me that  
24 Dr. Phillips was away during the two-day time frame  
25 during which the final autopsy report was prepared.  
Do I take it then that you were asked to sign the





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final autopsy report in his absense?

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A. That is correct.

4

Q. Prior to doing so, Doctor,

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did you have available to you the preliminary autopsy

6

report in a signed form?

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A. Yes, I did.

8

Q. Did you as well have discussions

9

with Dr. Taylor, who appears to have been the

10

resident who actually conducted this autopsy?

11

A. Yes, that is correct.

12

Q. Did you as well have an

13

opportunity to review the medical record of the  
child?

14

A. No, I did not.

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Cutz, dr.ex.  
(Cronk)

DD-3-1

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Q. Can you explain to me the process whereby the final autopsy report was presented to you for signature? Was this a report that you drafted, or was it a draft that Dr. Taylor had done and brought to you for signature?

A. Dr. Taylor was the draftee and I would sign it.

Q. Do you recall Doctor whether or not any amendments or corrections of any kind were made by you to the draft of the final autopsy report that Dr. Taylor brought to you?

A. We occasionally make changes, either to make certain points more clear, or believing some unnecessary things. I cannot recall whether this was done in this case. Taylor was a very good Resident, so I didn't have to ---

Q. I am not questioning that, believe me, Doctor.

A. So I think probably I have not altered it.

Q. Then I take it, Doctor, that, and please correct me if I am wrong, your total involvement with this case then was the participation and discussions with Dr. Taylor, for the purposes of reviewing the final autopsy report, and the review as





1  
2 well of the preliminary autopsy report and then the  
3 signing of the final?

4 A. Yes. Well in addition I  
5 also reviewed the microscopic slides.

6 Q. And was there any other  
7 involvement that you had with respect to the case  
8 before doing the sign-out and the final autopsy  
9 report?

10 A. No, I did not.

11 Q. Doctor, if we consider the  
12 findings that are set out in the final autopsy report,  
13 and I am looking now at the section under "Anatomical  
14 Diagnoses", the primary and predominant finding appears  
15 to be that of congenital heart disease with a variety  
16 of complications that are set out in some detail.  
17 Do I have that correctly, that was the predominant  
18 finding?

19 A. Yes.

20 Q. And secondly, Doctor, well,  
21 I am sorry, if we can turn from that to page 2 of  
22 the final autopsy report to the second final paragraph  
23 it is indicated that:

24 "Several factors may have contributed  
25 to the death of this infant, however  
no clear cause is defined."







1  
2 Doctor, can you help me, when you  
3 were presented with the case for final sign-out  
4 purposes, had this page been prepared?

5 A. Probably not.

6 Q. Was it your opinion at the  
7 time, Doctor, based on your review of the materials  
8 and the information that was available to you, that  
9 there was no clear cause of death which could be pin-  
pointed in this case?

10 A. Well there were findings but  
11 we felt that in the atmosphere, and since the case was  
12 under suspicion, we didn't want to write it off as  
13 a kind of case which would be a definite, there would  
14 be a definite uncontestable cause of death.

15 Q. How did you know, Doctor,  
16 that the case was under suspicion?

17 A. Because that was the reason  
18 I had to sign it, was that it had to be completed in  
19 a rush, that is how I got involved with the case.  
20 This was one of the cases included in the list of  
cases we were requested to review.

21 Q. And with respect to the matters  
22 that are dealt with in that paragraph then, Doctor,  
23 you have listed a number: First it is indicated that  
24 several factors may have contributed to the child's  
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Cutz, dr.ex.  
(Cronk)

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death. Then a number of those factors are set out?

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A. Yes.

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Q. And then you indicate that

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there was cardiomegally secondary to moderate  
aortic coarctation?

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A. That is correct.

7

Q. Secondly, focal myocardial

8

necrosis?

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A. Yes.

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Q. Thirdly there was massive

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amniotic, and I am afraid I may not pronounce this  
right, aspiration, and I am leaving out deliberately  
the word that precedes it, what is that condition?

13

A. Squame.

14

Q. Can you explain briefly what

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that is Doctor?

16

A. That is, the amniotic fat

17

contains a lot of desquamated cells from the skin of

18

the fetus, so that is why it is referred to as

19

squame, it is desquamated from the skin. Since it is

20

included in a sac and cannot get out, so by the time

21

that the full term - when the term comes to the full  
completion the sac is full of desquamated cells.

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THE COMMISSIONER: It is full of which?

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THE WITNESS: Desquamated cells.

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Q. I take it, Doctor, from the comments in the final paragraph, however, that that condition, although present at autopsy was not considered by you to be a likely factor to which death could be attributed, is that correct?

A. No, this was a significant finding in that a lot of the air spaces in the lung would be plugged by this material, and this is something which would have happened either shortly before or during delivery, the baby aspirating this fluid. It would have certainly caused some problems in oxygen exchange, in a sense it would act like pneumonitis, so it was quite a significant finding, but not one which you could definitely say this is the cause of death.

Q. And indeed Doctor, as I read that paragraph in the autopsy report, you suggest that it was: (a) significant with respect to contributing to the infant's respiratory distress: (b) you expressly indicate that the condition appeared to be resolving at the time of the death of the child, and it was not a likely explanation for the infant's cardiac arrest. I take it that was your opinion and conclusion at that time?

A. That is correct.





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Q. Are we then in a situation, Doctor, where the two factors which you felt might have contributed to the child's death are those which are set out immediately before that; they are the cardiomegally and the focal myocardial necrosis, those were the two possible contributing factors in your view to the child's death?

A. Yes.

Q. Now you have told me, Doctor, I think the word you used was "atmosphere" of those days?

A. That is correct.

Q. That this was not a death which you felt should be ruled out completely as a suspicious death?

A. That is correct.

Q. This may not be possible for you to answer this retrospectively, Doctor, but were either of the two contributing factors that you listed sufficient in your view at that stage, were it not for the events of the weekend involving other children, were either of those contributing factors either by themselves or in combinations sufficient to account for death?

A. That is kind of a long question.







1  
2 Q. Maybe I had better try again,  
3 that was perhaps unfair. You have told me Doctor  
4 that it was the atmosphere of the timing upon which  
5 you were asked to complete this report that led you  
6 to suggest that the cause of death was not completely  
7 clear, do I have that correctly?

8 A. Yes.

9 Q. And by the atmosphere of  
10 those days I take it you are referring to the deaths  
11 which had occurred over the immediately preceding  
12 weekend?

13 A. That is correct.

14 Q. And as well the investigation  
15 which resulted that Sunday from those deaths?

16 A. That is correct.

17 Q. At least the commencement of  
18 it?

19 A. That is correct.

20 Q. Had it not been for that  
21 investigation, Doctor, and had it not been for your  
22 knowledge of those deaths, as a pathologist were either  
23 of those two contributing factors in your view  
24 sufficient to account for this child's death?  
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A. I think it would be looked at in a different light. What I would say these opinions about cause of death are not really black and white, there is a gradation. There will be various grades of ...

Q. Certainty?

A. ... certainty about it, yes. So that this particular death would be in the intermediate category thing that, you know, the baby did definitely have quite a serious heart condition and had numbers of other findings which could possibly explain death. So that if there was no suspicion of some other possibilities, this case would not be considered.

Q. As?

A. As unexplained or something completely unexplained.

Q. Thank you, Doctor. Doctor, I take it then because of the deaths which had occurred over the preceding weekend and as well what you have described as the atmosphere at the Hospital at that time, the involvement of the police, that the possibility of digoxin intoxication as the cause or a contributing factor in this child's death was very much in your mind when you did the sign-out on





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this final autopsy report?

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A. Yes.

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Q. Was there anything,

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Doctor, to which your attention was drawn by the resident, Dr. Taylor, who had been involved in the conduct of the autopsy or anything from the clinical history of the child to which your attention was drawn by him which suggested to you the possibility of digoxin intoxication in this child?

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A. We had mainly discussion,

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if I am correct, regarding how to interpret the pathological findings, how extensive, how firm these diagnoses are. But we have not discussed in detail or went through any clinical detail because of the time limit.

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Q. You were doing this

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report under some time pressure?

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A. Yes.

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Q. Do I have it correctly,

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Doctor, that given the time constraints that were applying, there was nothing that was brought to your attention by Dr. Taylor or anyone else, be it from the clinical history of this child or be it from the pathological findings evident at autopsy, that was suggestive with respect to this child of digoxin





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intoxication?

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A. No.

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Q. All right. Thank you,  
doctor.

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Doctor, finally, if you could  
turn again to the first page of the final autopsy  
report. We see at the bottom of the first page a  
note indicating report on neuropathological examination  
to follow. Now, can you help us, Doctor, was that  
examination carried out?

11

A. Yes, it was.

12

Q. All right.

13

I have been provided, Doctor, by  
Mr. Batty of the Hospital with another copy of the  
final autopsy report on Kristin Inwood which, at  
page 11, entitled "Central Nervous System", appears  
to have -- I'm sorry, it discloses a number of  
comments and results with respect to the microscopic  
examination of the brain and as well with respect to  
the gross examination of the brain.

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A. Yes.

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Q. When you made reference

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in the final autopsy report to a neuropathological  
examination which was to follow, were you referring to  
an examination of the brain?

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A. That is correct.

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Q. And did that include

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both the findings with respect to the gross examination  
of the brain and as well the findings following  
microscopic examination of brain tissues?

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A. That is correct, yes.

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Q. And if we turn to page  
11, as it happens, of the copy of the final autopsy  
report that is contained in the medical record we  
see that it is blank.

9

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A. Yes.

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Q. I would ask you, Doctor,  
to look at the copy that has been provided to me and  
tell me if that is the neuropathological examination  
that was carried out -- the results of that examina-  
tion that were carried out on Kristin Inwood?

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A. Yes, that is correct.

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MS. CRONK: Mr. Commissioner, I  
only have one copy at this time.

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THE COMMISSIONER: Yes. I wonder  
if we can make it 113B.

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--- EXHIBIT NO. 113B:

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Page 11 of the Final  
Autopsy Report, Kristin  
Inwood.

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THE COMMISSIONER: Are we going  
to tell everybody what it says or not?

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MS. CRONK: Mr. Commissioner, I will obviously make copies and it is obvious from the time of day that the doctor will be returning.

Q. Could I ask you simply at this stage, Doctor, was there anything that was disclosed as a result either of the gross visual examination of the brain or as a result of the microscopic examination which suggested a difficulty or some abnormality in the brain which could have contributed to death?

A. There was no significant findings.

Q. Doctor, I am curious as well by virtue of the fact that that page appears blank in the copies of the final autopsy report in the medical record, yet we see that there is another version which does include it.

Was it performed -- I take it that the results of that examination were available at some time after you signed out the final autopsy report?

A. That is correct, yes.

Q. All right.

Can you help us today, do you know





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how long after the signing out those tests results were made available to you?

A. It wouldn't have taken much longer than maybe a couple of weeks.

Q. The results of the gross examination of the brain I take it would have been results that were recorded and available to Dr. Taylor, do I have that correctly?

A. Yes.

Q. Who then conducted the microscopic examination of the brain?

A. It would be Dr. Taylor. together reviewing it with the neuropathologist, which, in this instance, would be Dr. Becker.

Q. All right.

And I take it that that had not been done at the time the report was being signed out but was subsequently done?

A. That is correct.

Q. All right.

And then the results of that in combination with the results of the gross examination were provided to the Medical Records Department as part of the final autopsy report?

A. That is correct, yes.







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EE72

MS. CRONK: Thank you, doctor.

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Mr. Commissioner, I am conscious of the time and I am about to move to the case of Allana Miller.

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THE COMMISSIONER: Yes, I guess not.

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MS. CRONK: Perhaps

for the assistance of other counsel, next week, as other counsel know, is to be taken up with the evidence of Drs. Taylor and Costigan. The Monday next after that is the Monday of the Thanksgiving weekend but Dr. Cutz is available to return on Tuesday, October 11th, and has agreed to complete his evidence at that time.

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THE COMMISSIONER: Yes.

You are of course here and you are at The Sick Children's Hospital, yes. Well, we will see what the situation is next Thursday and with all probability that will be when we will ask you to come back. We will keep in touch.

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MS. CRONK: Thank you, doctor.

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THE WITNESS: Thank you.

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THE COMMISSIONER: Nothing else?  
Then until Monday at ten o'clock.

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--- whereupon the hearing was adjourned until Monday, the 3rd day of October 1983, at 10:00 a.m.

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